

94 33501

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ETHEL MAE BOSTWICK				2. DATE OF DEATH MONTH 10 DAY 30 YEAR 94		3. TIME OF DEATH 0255 A M	
4. SOCIAL SECURITY NUMBER 218-28-4970		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 64 YRS.		7. DATE OF BIRTH (Month, Day, Year) 7/19/1930	
9a. FACILITY NAME (If not institution, give street and number) SACRED HEART HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND		9c. COUNTY OF DEATH ALLEGANY	
RESIDENCE OF DECEDENT							
10a. STATE PA		10b. COUNTY BEDFORD		10c. CITY, TOWN OR LOCATION BUFFALO MILLS		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER R. D. 1, BOX 172				10f. ZIP CODE 15534		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) DELBERT ORANGE PENSYL				18. MOTHER'S NAME (First, Middle, Maiden Surname) LAVADA PEARL COUGHENOUR			
19a. INFORMANT'S NAME (Type/Print) RICHARD H. BOSTWICK				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 705 HYDE PARK RD, BALTIMORE, MD 21221-6020			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DRY RIDGE CEMETERY 11/1/94		DATE RD, BUFFALO MILLS,		20c. LOCATION — City or Town, State PA	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Harvey H. Zeigler</i>				22. NAME AND ADDRESS OF FACILITY HARVEY H. ZEIGLER FUNERAL HOME HYNDMAN, PA 15545-0636			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → METASTATIC CARCINOMA OF LUNG							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes mellitus, coronary artery disease Gastroesophageal reflux disease							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>H. Sidhu</i>				29c. LICENSE NUMBER D 26507		29d. DATE SIGNED (Month, Day, Year) 10/31/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. HARJIT SIDHU, M.D., 925 BISHOP WALSH ROAD, CUMBERLAND, MD 21502							
31. DATE FILED (Month, Day, Year) OCT 31 1994				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Amended #20b, 11/2/94, L.S., Somerset Co.

94 33502

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ALTON CHRISTOPHER BALL				2. DATE OF DEATH MONTH 10 DAY 31 YEAR 94		3. TIME OF DEATH 1650 M	
4. SOCIAL SECURITY NUMBER 190-16-8932		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 90 YRS.		7. DATE OF BIRTH (Month, Day, Year) 3/17/04	
8. FACILITY NAME (If not Institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				9. CITY, TOWN OR LOCATION OF DEATH SALISBURY		10. COUNTY OF DEATH WICOMICO	
11. RESIDENCE OF DECEDENT 10a. STATE Maryland 10b. COUNTY Wicomico 10c. CITY, TOWN OR LOCATION Eden 10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 10e. STREET AND NUMBER 3177 Meadowbridge Road 10f. ZIP CODE 21822 10g. CITIZEN OF WHAT COUNTRY? U.S.							
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) Farmer		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Farmer		16b. KIND OF BUSINESS/INDUSTRY Agriculture			
17. FATHER'S NAME (First, Middle, Last) Charles Christopher Ball				18. MOTHER'S NAME (First, Middle, Maiden Surname) Bertha Brewington Ball			
19a. INFORMANT'S NAME (Type/Print) Donald Ball		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3271 Meadowbridge Rd, Eden, Md 21822					
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, funeral home, or other place) Asbury Cemetery 11/2		20c. LOCATION — City or Town, State Mount Vernon, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE James J. Hinn M00295				22. NAME AND ADDRESS OF FACILITY Hinman Funeral Home Princess Anne, Md 21853			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Ischemic Cardiomyopathy Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. Ischemic Cardiomyopathy DUE TO (OR AS A CONSEQUENCE OF): b. Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate interval between Onset and Death years years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1. <input checked="" type="checkbox"/> Natural 5. <input type="checkbox"/> Pending Investigation 2. <input type="checkbox"/> Accident 6. <input type="checkbox"/> Could not be determined 3. <input type="checkbox"/> Suicide 4. <input type="checkbox"/> Homicide					
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1. <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Jeffrey Etherton, MD				29c. LICENSE NUMBER D 36783		29d. DATE SIGNED (Month, Day, Year) 10 31 94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Jeffrey Etherton, MD, PRMC, Salisbury, MD 21801							
31. DATE FILED (Month, Day, Year) NOV 02 1994				32. REGISTRAR'S SIGNATURE John Davidson-Randall			

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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SECTION FIBER

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NOV 12 1981

94 33503

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Brown, James</i>				2. DATE OF DEATH MONTH <i>10</i> DAY <i>31</i> YEAR <i>1984</i>		3. TIME OF DEATH <i>0840</i> M	
4. SOCIAL SECURITY NUMBER 220-16-4793		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 68 YRS.		7. DATE OF BIRTH (Month, Day, Year) OCT. 25 1926	
9a. FACILITY NAME (If not institution, give street and number) ANNE ARUNDEL MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH ANNAPOLIS		9c. COUNTY OF DEATH ANNE ARUNDEL	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY ANNE ARUNDEL		10c. CITY, TOWN OR LOCATION ANNAPOLIS		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 17 BLOOMSBURY SQUARE				10f. ZIP CODE 21401		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1945 - 1946		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th</i> College (1-4 or 5+) _____				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) TRUCK STOCKER		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) CHARLES D. BROWN				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY E. BRICE			
19a. INFORMANT'S NAME (Type/Print) GERALDINE BROWN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17 BLOOMSBURY SQUARE ANNAPOLIS, MD. 21401			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MARYLAND VETERAN CEMETERY 11/4/84 CROWNSVILLE, MD.		20c. LOCATION — City or Town, State		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Larry Reese</i>				22. NAME AND ADDRESS OF FACILITY REESE & SONS MORTUARY, P.A. 821 WEST STREET, ANNAPOLIS, MD. 21401			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <i>Pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Stroke</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>Atrial fibrillation</i> DUE TO (OR AS A CONSEQUENCE OF): d. _____							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> MEDICAL EXAMINER: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <i>[Signature]</i> 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature] PH.D., D.O.</i>		29c. LICENSE NUMBER <i>A36078</i>		29d. DATE SIGNED (Month, Day, Year) <i>10-31-84</i>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Steve D. Kulla 900 Bayshore Rd, Suite 300, Annapolis, MD 21403</i>							
31. DATE FILED (Month, Day, Year) <i>10 NOV 03 1994</i>		32. REGISTRAR'S SIGNATURE <i>John Andrew Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial certificate. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED FROM THE REBELS

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RECEIVED FROM THE REBELS

94-6243-013

B.K.S

ITEMS: 23 PART I, 27, PER MEO FILM G-717 11/18/94 t.t

94 33504

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) RUSSELL WILLIAM CAIN			2. DATE OF DEATH MONTH DAY YEAR OCT. 30 94		3. TIME OF DEATH 1:13 P M
4. SOCIAL SECURITY NUMBER 212-38-0018	5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 55 YRS.	7. DATE OF BIRTH (Month, Day, Year) Sept. 19, 1939	8. BIRTHPLACE (State or Foreign Country) Pa.	
9a. FACILITY NAME (If not institution, give street and number) CARROLL COUNTY GENERAL HOSP.			9b. CITY, TOWN OR LOCATION OF DEATH WESTMINSTER		9c. COUNTY OF DEATH CARROLL
10a. STATE MD		10b. COUNTY Carroll	10c. CITY, TOWN OR LOCATION Taneytown		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
10e. STREET AND NUMBER 99 Grand Dr.			10f. ZIP CODE 21787		10g. CITIZEN OF WHAT COUNTRY? USA.
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Carroll County Roads		16b. KIND OF BUSINESS/INDUSTRY County Govt.	
17. FATHER'S NAME (First, Middle, Last) Raymond R. Cain			18. MOTHER'S NAME (First, Middle, Maiden Surname) Edna Mae Cartzendafner		
19a. INFORMANT'S NAME (Type/Print) Alice M. Eckard			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1701 Old New Windsor Rd. New Windsor, Md. 21776		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Pipe Creek Cem. 11/3		20c. LOCATION — City or Town, State Nr. New Windsor	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 			22. NAME AND ADDRESS OF FACILITY D.D. Hartzler P.O. Box 249 New Windsor, Md. 21776		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):					Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER 			29c. LICENSE NUMBER O.C.M.E		29d. DATE SIGNED (Month, Day, Year) OCT. 31, 1994
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201					
31. DATE FILED (Month, Day, Year) NOV 02 1994		32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0070
 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Amended # 206, 10/26/94, J.W. Montgomery Co.

94 33505

1 -
FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) George Arthur Cook, Jr.				2. DATE OF DEATH MONTH DAY YEAR October 21, 1994		3. TIME OF DEATH 4:50 P M					
4. SOCIAL SECURITY NUMBER 218-20-0015		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		7. DATE OF BIRTH (Month, Day, Year) October 4, 1921		8. BIRTHPLACE (State or Foreign Country) Washington, D.C.			
9a. FACILITY NAME (If not institution, give street and number) Wheaton Manor Care				9b. CITY, TOWN OR LOCATION OF DEATH Wheaton			9c. COUNTY OF DEATH Montgomery				
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				
10e. STREET AND NUMBER 1117 Notley Road				10f. ZIP CODE 20904		10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+)		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Manager GEICO			16b. KIND OF BUSINESS/INDUSTRY Insurance						
17. FATHER'S NAME (First, Middle, Last) George Arthur Cook, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Helen McKee Grandfield							
19a. INFORMANT'S NAME (Type/Print) Alice Jane Cook				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1117 Notley Road Silver Spring, Maryland 20904							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arlington National Cemetery 10/26/94 10/29/94			20c. LOCATION — City or Town, State Arlington, Virginia						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Christopher Madbu				22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901							
23. PART I. Enter the disease(s), or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Multiple Myeloma DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. pneumonia emphysema								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER Dennis R. Schomer MD						29c. LICENSE NUMBER D15665		29d. DATE SIGNED (Month, Day, Year) 10/24/94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dennis R. Schomer MD 1420 Laurel Park Dr # 102 Laurel MD 20707											
31. DATE FILED (Month, Day, Year) OCT 26 1994						32. REGISTRAR'S SIGNATURE Jina Davidson-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33507

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Mary Louise Josephine G. Clark</i>				2. DATE OF DEATH MONTH DAY YEAR <i>OCT 26 94</i>		3. TIME OF DEATH <i>12:35 P M</i>	
4. SOCIAL SECURITY NUMBER <i>288-42-4531</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>84</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Jan 25, 1910</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Fox Chase Nursing Home</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Bethesda</i>		9c. COUNTY OF DEATH <i>Montgomery</i>	
RESIDENCE OF DECEDENT							
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Montgomery</i>		10c. CITY, TOWN OR LOCATION <i>Chevy Chase</i>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>7007 Connecticut Avenue</i>				10f. ZIP CODE <i>20815</i>		10g. CITIZEN OF WHAT COUNTRY? <i>United States</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>6</i> College (1-4 or 5+) <i>6</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Music Teacher</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Education</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Harry Finlus Glancy</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Katherine Ellen Goodmiller Wilhelm</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Nancy Clark Smith (Daughter)</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>Same as #10</i>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Suburban Crematory</i>		DATE <i>10-27</i>		20c. LOCATION — City or Town, State <i>Silver Spring, MD</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>J. B. Clark</i>				22. NAME AND ADDRESS OF FACILITY <i>Rapp Funeral Services, P.A. 933 Gist Ave, Silver Spring, MD 20910</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Hypercalcemia</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Carcinoma of the Uterus</i> DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED					
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John Taulman</i>				29c. LICENSE NUMBER <i>208546</i>		29d. DATE SIGNED (Month, Day, Year) <i>Oct 27 94</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>John Taulman 8218 Wisconsin Ave. No.</i>							
31. DATE FILED (Month, Day, Year) <i>OCT 28 1994</i>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Amended #1 #29d 10/28/94 MRT Montgomery County 94 33508
FOR
1. STATE REGISTRAR 'STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Stewart P. Stewart-Crum				2. DATE OF DEATH MONTH DAY YEAR October 22, 1994		3. TIME OF DEATH 10:45 PM					
4. SOCIAL SECURITY NUMBER 215-44-8172		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 14, 1909		8. BIRTHPLACE (State or Foreign Country) Pennsylvania			
9a. FACILITY NAME (If not institution, give street and number) Montgomery General Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Olney			9c. COUNTY OF DEATH Montgomery				
RESIDENCE OF DECEDENT											
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				
10e. STREET AND NUMBER 3702 Dulwick Drive				10f. ZIP CODE 20906		10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Civil Engineer			16b. KIND OF BUSINESS/INDUSTRY Federal Government						
17. FATHER'S NAME (First, Middle, Last) Thomas M. Crum				18. MOTHER'S NAME (First, Middle, Maiden Surname) Marion Cairney							
19a. INFORMANT'S NAME (Type/Print) Agnes M. Crum				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3702 Dulwick Drive Silver Spring, MD 20906							
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 10/25/94		DATE 10/25/94		20c. LOCATION — City or Town, State Alexandria, Virginia					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Andrew J. Cole				22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Emphysema</u> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. _____ c. _____ d. _____ PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Lower GI bleeding</u> <u>Osteoporosis</u>							Approximate interval Between Onset and Death 6 yr.				
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28i. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER Frank J. Mayo, MD				29c. LICENSE NUMBER D 23630		29d. DATE SIGNED (Month, Day, Year) 10-28-94					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Frank J. Mayo, MD 16220 Frederick RD #213, Gith, MD 20817											
31. DATE FILED (Month, Day, Year) OCT 28 1994				32. REGISTRAR'S SIGNATURE Julia Davidson-Rendall							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Amended #18, 10/28/94, J. W. Montgomery Co.

94 33509

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Infant Chipak				2. DATE OF DEATH MONTH DAY YEAR October 20, 1994		3. TIME OF DEATH 0912 AM									
4. SOCIAL SECURITY NUMBER N/A		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. MONTHS DAYS 3 3 3		7. DATE OF BIRTH (Month, Day, Year) October 20, 1994		8. BIRTHPLACE (State or Foreign Country) Maryland							
9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring			9c. COUNTY OF DEATH Montgomery								
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO								
10e. STREET AND NUMBER 1909 Agate Drive				10f. ZIP CODE 20904		10g. CITIZEN OF WHAT COUNTRY? U.S.A.									
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White								
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) N/A		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) N/A		15b. KIND OF BUSINESS/INDUSTRY N/A											
17. FATHER'S NAME (First, Middle, Last) John L. Chipak				18. MOTHER'S NAME (First, Middle, Maiden Surname) Patricia Farrell Fairall											
19a. INFORMANT'S NAME (Type/Print) John Chipak				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1909 Agate Drive Silver Spring, Maryland 20904											
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Mark's Episcopal Church			20c. LOCATION — City or Town, State Silver Spring, Maryland		20d. DATE 10/24/94								
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Timothy J. Campbell				22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. EXTREME IMMATURITITY DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate interval Between Onset and Death 3 hrs							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) N/A		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED							
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29b. SIGNATURE AND TITLE OF CERTIFIER Katherine C. White MD Staff Neonatologist		29c. LICENSE NUMBER D28737		29d. DATE SIGNED (Month, Day, Year) 10/20/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Katherine C. White, M.D. Holy Cross Hospital 1500 Forest Glen Rd. Silver Spring MD															
31. DATE FILED (Month, Day, Year) OCT 25 1994				32. REGISTRAR'S SIGNATURE John Davidson-Randall											

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33510

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) DORA M. COHEN				2. DATE OF DEATH MONTH DAY YEAR OCT. 24, 1994		3. TIME OF DEATH 12:55 AM	
4. SOCIAL SECURITY NUMBER 188-18-2190		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 89 YRS.		7. DATE OF BIRTH (Month, Day, Year) MAY 17, 1905	
9a. FACILITY NAME (If not institution, give street and number) SHADY GROVE ADVENTIST HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH ROCKVILLE		9c. COUNTY OF DEATH MONTGOMERY	
RESIDENCE OF DECEDENT							
10a. STATE MD.		10b. COUNTY MONTGOMERY		10c. CITY, TOWN OR LOCATION GAITHERSBURG		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 19310 CLUB HOUSE RD.				10f. ZIP CODE 20879		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SELF EMPLOYED-OWNER		16b. KIND OF BUSINESS/INDUSTRY CONFECTIONARY/BAKERY			
17. FATHER'S NAME (First, Middle, Last) AARON KAUFMAN				18. MOTHER'S NAME (First, Middle, Maiden Surname) REBECCA UNKNOWN			
19a. INFORMANT'S NAME (Type/Print) CHARLOTTE FOWLER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 208 LEDGERWOOD RD. #1, HOT SPRINGS, ARKANSAS 71913			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) CHAMBERS CREMATORY 10/25		20c. LOCATION — City or Town, State RIVERDALE, MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE W. W. Chambers MOOO91				22. NAME AND ADDRESS OF FACILITY W. W. CHAMBERS CO., RIVERDALE, MD. 20737			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MYOCARDIAL INFARCTION DUE TO (OR AS A CONSEQUENCE OF): b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): c. FRACTURED RIGHT HIP DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death ACUTE INDEF.
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 10-10-94		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURED FELL		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) HOME		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) #10	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Francis C. Mayle				29c. LICENSE NUMBER D07099		29d. DATE SIGNED (Month, Day, Year) 10/24/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FRANCIS C. MAYLE 10215 FERNWOOD RD., BETHESDA, MD. 20817-1106							
31. DATE FILED (Month, Day, Year) OCT 27 1994				32. REGISTRAR'S SIGNATURE John Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit card.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33511

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CATHERINE LESTER CONNORS				2. DATE OF DEATH MONTH DAY YEAR OCTOBER 22, 1994		3. TIME OF DEATH 10:00 A. M	
4. SOCIAL SECURITY NUMBER 577-01-1092		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) JUNE 11, 1911	
8. BIRTHPLACE (State or Foreign Country) IOWA				9a. FACILITY NAME (If not institution, give street and number) 3330 GLENEAGLES DRIVE, #1-D		9b. CITY, TOWN OR LOCATION OF DEATH SILVER SPRING	
9c. COUNTY OF DEATH MONTGOMERY				10a. STATE MARYLAND		10b. COUNTY MONTGOMERY	
10c. CITY, TOWN OR LOCATION SILVER SPRING				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 3330 GLENEAGLES DRIVE, #1-D	
10f. ZIP CODE 20906				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) SECRETARY				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SECRETARY		16b. KIND OF BUSINESS/INDUSTRY UNIVERSITY SCHOOL OF NURSING	
17. FATHER'S NAME (First, Middle, Last) EDWIN LESTER				18. MOTHER'S NAME (First, Middle, Maiden Surname) CATHERINE UNKNOWN			
19a. INFORMANT'S NAME (Type/Print) CATHERINE A. CONNORS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7059 DEER VALLEY ROAD, HIGHLAND, MARYLAND 20777			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GATE OF HEAVEN CEMETERY 10/25/94 SILVER SPRING, MD		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Francis J. Collins</i>				22. NAME AND ADDRESS OF FACILITY FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W., SIL. SP., MD 20901			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Multiple MYELOMA</i> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Joseph Kaplan MD</i>		29c. LICENSE NUMBER D35635		29d. DATE SIGNED (Month, Day, Year) 10/25/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOSEPH KAPLAN, MD 7120 CONTEE ROAD, #410, LAUREL, MD							
31. DATE FILED (Month, Day, Year) OCT 27 1994				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33512

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Paula Coste				2. DATE OF DEATH MONTH DAY YEAR October 21, 1994				3. TIME OF DEATH 10:30 AM					
4. SOCIAL SECURITY NUMBER 094-24-6218		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 20, 1916		8. BIRTHPLACE (State or Foreign Country) Austria					
9a. FACILITY NAME (If not institution, give street and number) 9039 Sligo Creek Parkway, #904						9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring				9c. COUNTY OF DEATH Montgomery			
RESIDENCE OF DECEDENT													
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER 9039 Sligo Creek Parkway, #904				10f. ZIP CODE 20901				10g. CITIZEN OF WHAT COUNTRY? United States					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Administrative Clerk				16b. KIND OF BUSINESS/INDUSTRY Telephone Book					
17. FATHER'S NAME (First, Middle, Last) Guda Drechsler						18. MOTHER'S NAME (First, Middle, Maiden Surname) Sophie Adele Kauf							
19a. INFORMANT'S NAME (Type/Print) George S. Coste				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1416 Foggy Glen Court, Silver Spring, MD 20906									
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc. 10/22/94 DATE				20c. LOCATION — City or Town, State Bethesda, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Barbara J. Muller Lawrence</i> MO0831				22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.										Approximate interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John T. Anderson</i>						29c. LICENSE NUMBER D08546		29d. DATE SIGNED (Month, Day, Year) Oct 21-94					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>John T. Anderson</i> 8218 Wisconsin Ave NW Bethesda													
31. DATE FILED (Month, Day, Year) OCT 24 1994				32. REGISTRAR'S SIGNATURE <i>Greta Davidson-Randell</i>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

Amended #1, #11, 10/24/94 M&T Montgomery City 94 33513
FOR STATE REGISTRAR
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ADOLPH D. CARLSEN			2. DATE OF DEATH MONTH 10 DAY 20 YEAR 1994		3. TIME OF DEATH 7:15 A.M.		
4. SOCIAL SECURITY NUMBER 065-05-3042		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 84 YRS.			
7. DATE OF BIRTH (Month, Day, Year) May 1, 1910		8. BIRTHPLACE (State or Foreign Country) California					
9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital			9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery		
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Wheaton			
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 3504 Weller Road			10f. ZIP CODE 20906		10g. CITIZEN OF WHAT COUNTRY? USA		
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) PBX Installer		15b. KIND OF BUSINESS/INDUSTRY C & P Telephone			
17. FATHER'S NAME (First, Middle, Last) Richard Johnson			18. MOTHER'S NAME (First, Middle, Maiden Surname) Constance Amelia Dishington				
19a. INFORMANT'S NAME (Type/Print) Mary Catherine Carlsen			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3504 Weller Road Wheaton, Maryland 20906				
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 10/22/94 Silver Spring, Maryland		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Christopher Marshall</i>			22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → hypoxemia						1 day	
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST						3 days	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Steve J. Boyle</i>				29c. LICENSE NUMBER D15625		29d. DATE SIGNED (Month, Day, Year) 10/20/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Daniel J. Boyle, M.D. 10313 Georgia Avenue #201 Silver Spring, Maryland 20902							
31. DATE FILED (Month, Day, Year) OCT 24 1994		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Bondell</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33514

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Many Hocking Clough</i>				2. DATE OF DEATH MONTH <i>10</i> DAY <i>28</i> YEAR <i>94</i>		3. TIME OF DEATH <i>17:40 PM</i>	
4. SOCIAL SECURITY NUMBER <i>179-26-5665</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (in yrs. last birthday) <i>61</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>7-30-33</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Union Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Elkton</i>		9c. COUNTY OF DEATH <i>Cecil</i>	
RESIDENCE OF DECEDENT							
10a. STATE <i>DE</i>		10b. COUNTY <i>New Castle</i>		10c. CITY, TOWN OR LOCATION <i>Wilmington</i>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>2003 Lincoln Avenue</i>				10f. ZIP CODE <i>19808</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>white</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) <i>2</i> College (14 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>registered nurse</i>		16b. KIND OF BUSINESS/INDUSTRY <i>hospital</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Willis Hocking</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Julia Desmond</i>			
19a. INFORMANT'S NAME (Type/Print) <i>James H. Clough, Sr.</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2003 Lincoln Avenue, Wilmington, DE 19808</i>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Union Hill Cemetery 11-1-94</i>		DATE <i>11-1-94</i>		20c. LOCATION — City or Town, State <i>Kennett Square, PA</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Russell G. G...</i>		#123		22. NAME AND ADDRESS OF FACILITY <i>Foulk & Gofus Funeral Home, Inc. 200 Rosehill Rd., W. Grove, PA 19390</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. atherosclerotic cardiovascular disease</i> DUE TO (OR AS A CONSEQUENCE OF): Sequitely flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>b. hypertension</i> DUE TO (OR AS A CONSEQUENCE OF): <i>c. cigarette usage</i> DUE TO (OR AS A CONSEQUENCE OF): Approximate interval Between Onset and Death <i>years</i> <i>years</i> <i>years</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>renal failure with hemodialysis</i>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <i>1</i>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>W. Bruce Obenshain, M.D.</i>				29c. LICENSE NUMBER <i>D35779</i>		29d. DATE SIGNED (Month, Day, Year) <i>10/28/94</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>W. Bruce Obenshain, Union Hospital, Cecil County, Emer. Dept. Elkton, MD 21913</i>							
31. DATE FILED (Month, Day, Year) <i>OCT 31 '94</i>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33515

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Ella Louise Cato				2. DATE OF DEATH MONTH DAY YEAR October 24 94		3. TIME OF DEATH 1205 P M	
4. SOCIAL SECURITY NUMBER 213-28-6645		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 62 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec. 10, 1931	
9a. FACILITY NAME (If not institution, give street and number) Union Hospital of Cecil County				9b. CITY, TOWN OR LOCATION OF DEATH Elkton		9c. COUNTY OF DEATH Cecil	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Cecil		10c. CITY, TOWN OR LOCATION Elkton		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 31 Star Route Road				10f. ZIP CODE 21921		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Quality Control Inspector		16b. KIND OF BUSINESS/INDUSTRY Food Service			
17. FATHER'S NAME (First, Middle, Last) Joseph E. Gallaher				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mildred M. Thompson			
19a. INFORMANT'S NAME (Type/Print) Joyce A. George				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31 Star Route Road - Elkton, MD 21921			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cherry Hill Methodist Cem. 10-27-94		20c. LOCATION — City or Town, State Cherry Hill, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Donald S. Hicks				22. NAME AND ADDRESS OF FACILITY Hicks Home for Funerals, P.A. 103 West Stockton Street Elkton, MD 21921-5521			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. acute myocardial Infarction and cereb.							
DUE TO (OR AS A CONSEQUENCE OF): b. old CVA.							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST c. 7x. RD hip.							
DUE TO (OR AS A CONSEQUENCE OF): d. Diabetic Mellitus							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Jui Chih Hsu MD				29c. LICENSE NUMBER D04823		29d. DATE SIGNED (Month, Day, Year) 10/25/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Jui Chih Hsu, MD 223 West main st. Elkton MD 21921							
31. DATE FILED (Month, Day, Year) OCT 28 '94				32. REGISTRAR'S SIGNATURE John Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33516

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) James Wilson Chesser				2. DATE OF DEATH MONTH Oct DAY 15 YEAR 1994		3. TIME OF DEATH 10:37 P M	
4. SOCIAL SECURITY NUMBER 225-05-2693		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov 1, 1915	
9a. FACILITY NAME (If not institution, give street and number) Prince George's Hospital Center				9b. CITY, TOWN OR LOCATION OF DEATH Cheverly		9c. COUNTY OF DEATH Prince George's	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Upper Marlboro		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 17211 Clagett Landing Road				10f. ZIP CODE 20772		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Investigator/CIA		16b. KIND OF BUSINESS/INDUSTRY Federal Government			
17. FATHER'S NAME (First, Middle, Last) Walter Cleveland				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Milburn			
19a. INFORMANT'S NAME (Type/Print) Frances Chesser				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17211 Clagett Landing Road, Upper Marlboro, Md 20772			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. George Church Cem. 1994		20c. LOCATION — City or Town, State Valley Lee, Maryland		20d. LOCATION — City or Town, State Valley Lee, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc 6633 Old Alexander Ferry Road, Clinton, Md 20735			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Cancer of the Liver DUE TO (OR AS A CONSEQUENCE OF): b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____							Approximate interval Between Onset and Death Months
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Augusto P. Rodriguez MD				29c. LICENSE NUMBER D21230		29d. DATE SIGNED (Month, Day, Year) October 16, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print) Augusto P. Rodriguez, M.D., 5009 Rayburn Court, Camp Springs, MD 20748-2230							
31. DATE FILED (Month, Day, Year) OCT 25 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33517

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ADELINE, COUSINS				2. DATE OF DEATH MONTH 10 - DAY 24 - YEAR 1994		3. TIME OF DEATH 5:30 PM	
4. SOCIAL SECURITY NUMBER 578-26-472		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 94 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 7, 1900	
8. BIRTHPLACE (State or Foreign Country) Washington, D.C.				9. COUNTY OF DEATH MONTGOMERY			
9a. FACILITY NAME (If not institution, give street and number) GROSVENOR HEALTHCARE				9b. CITY, TOWN OR LOCATION OF DEATH BETHESDA			
10a. STATE MD				10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Bethesda	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER 5721 GROSVENOR PLANE				10f. ZIP CODE 20814		10g. CITIZEN OF WHAT COUNTRY? U.S.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6th College (1-4 or 5+) 				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Domestic		16b. KIND OF BUSINESS/INDUSTRY Private	
17. FATHER'S NAME (First, Middle, Last) Andrew Jenkins				18. MOTHER'S NAME (First, Middle, Maiden Surname) Susie Perry			
19a. INFORMANT'S NAME (Type/Print) Milford Eugene Ware, Jr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) #507 780 Fairview Ave., Takoma Park, MD 20912			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arlington National Cemetery 10/28/94		20c. LOCATION — City or Town, State Arlington, VA			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE John T. Stewart, III				22. NAME AND ADDRESS OF FACILITY Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Chronic Renal Failure DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. 							Approximate Interval Between Onset and Death Months
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. None							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER John T. Stewart, III				29c. LICENSE NUMBER D20516		29d. DATE SIGNED (Month, Day, Year) 10/24/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Isabel Schalmann 9410 0 11 Georgetown Rd Bethesda MD							
31. DATE FILED (Month, Day, Year) 1 OCT 27 1994				32. REGISTRAR'S SIGNATURE Richardson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL, DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33518

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) WILLIAM CHESHIRE				2. DATE OF DEATH MONTH October DAY 22 , 1994				3. TIME OF DEATH 7:50 P M	
4. SOCIAL SECURITY NUMBER 232-26-2618		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 73 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0		7. DATE OF BIRTH (Month, Day, Year) 12/12/20	
9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Cumberland				9c. COUNTY OF DEATH Allegany	
RESIDENCE OF DECEDENT									
10a. STATE Wv.		10b. COUNTY Mineral		10c. CITY, TOWN OR LOCATION Piedmont				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 100 East Hampshire St.				10f. ZIP CODE 26750		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WHITE		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Pipefitter, Plumber			16b. KIND OF BUSINESS/INDUSTRY Trade		
17. FATHER'S NAME (First, Middle, Last) James Cheshire				18. MOTHER'S NAME (First, Middle, Maiden Surname) Carrie (Herndon) Cheshire					
19a. INFORMANT'S NAME (Type/Print) Elaine Cheshire				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 East Hampshire St. Piedmont Wv. 26750					
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Philos Cemetery 10/25/94		20c. LOCATION — City or Town, State Westernport, Md			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Fredlock Funeral Home P.O. Box 4, Piedmont Wv. 26750					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Myocardial Infarction a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST									Approximate interval Between Onset and Death Immediate
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO									
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)					
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D 17246		29d. DATE SIGNED (Month, Day, Year) 10/23/94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Richard Snider M.D. Memorial Hospital Suite 402 Cumberland MD 21502									
31. DATE FILED (Month, Day, Year) OCT 27 1994				32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020
 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. The funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33519

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) Helen Cecilia Cain				2. DATE OF DEATH MONTH 10 DAY 22 YEAR 94		3. TIME OF DEATH 5P M	
4. SOCIAL SECURITY NUMBER 214 32 3735		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 90 YRS.		7. DATE OF BIRTH (Month, Day, Year) 8/2/04	
9a. FACILITY NAME (If not institution, give street and number) FROSTBURG VILLAGE NURSING HOME				9b. CITY, TOWN OR LOCATION OF DEATH FROSTBURG		9c. COUNTY OF DEATH ALLEGANY	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY ALLEGANY		10c. CITY, TOWN OR LOCATION FROSTBURG		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 9 WASHINGTON STREET				10f. ZIP CODE 21532		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SALES		16b. KIND OF BUSINESS/INDUSTRY G. C. MURPHY CO.	
17. FATHER'S NAME (First, Middle, Last) MICHAEL ROONEY				18. MOTHER'S NAME (First, Middle, Maiden Surname) ELLEN BARRY			
19a. INFORMANT'S NAME (Type/Print) PATRICIA C. BRAILER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 WASHINGTON STREET, FROSTBURG, MD 21532			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ST. MICHAEL'S CEMETERY		20c. LOCATION — City or Town, State 10/25 FROSTBURG, MD 21532		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Mark M. Sowers</i>				22. NAME AND ADDRESS OF FACILITY SOWERS FUNERAL HOME, P.A. 60 W. MAIN ST., FROSTBURG, MD 21532			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Coronary Artery Disease - Cpt. B.B.B. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 2 MONTHS							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Organic Brain Syndrome - Dementia							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Charles Hyun H. M.D.</i>				29c. LICENSE NUMBER D24951		29d. DATE SIGNED (Month, Day, Year) Oct 25, 94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CHARL H. HYUN OH. MD 48 STAR TERRACE, FROSTBURG, MD 21532							
31. DATE FILED (Month, Day, Year) OCT 26 1994		32. REGISTRAR'S SIGNATURE <i>Paula Randall</i>					

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0022

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1947-48



1947-48

94 33520

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Ruth Geddes Curtis				2. DATE OF DEATH MONTH DAY YEAR October 27 1994		3. TIME OF DEATH 11:10P M	
4. SOCIAL SECURITY NUMBER 030-36-7954		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 85 YRS.	7. DATE OF BIRTH (Month, Day, Year) Dec 11 1908		8. BIRTHPLACE (State or Foreign Country) Michigan	
9a. FACILITY NAME (If not institution, give street and number) Ginger Cove Health Center				9b. CITY, TOWN OR LOCATION OF DEATH Annapolis		9c. COUNTY OF DEATH Anne Arundel	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Annapolis		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 7104 River Crescent Drive				10f. ZIP CODE 21401		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Home			
17. FATHER'S NAME (First, Middle, Last) Robert Geddes				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mabel Slocum			
19a. INFORMANT'S NAME (Type/Print) David Curtis				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4100 Necostin Annandale, Virginia 22003			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Ft. Lincoln Crematory 10/29/94		20c. LOCATION — City or Town, State Brentwood, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Laine J. Phillips</i>				22. NAME AND ADDRESS OF FACILITY John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Pneumonia</i> a. DUE TO (OR AS A CONSEQUENCE OF): <i>CVA + aspiration</i> b. DUE TO (OR AS A CONSEQUENCE OF): <i>HASCD</i> c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death 1 month 1 month
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Dementia</i>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Michael J. LaPenta</i>				29c. LICENSE NUMBER 021438		29d. DATE SIGNED (Month, Day, Year) October 28, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Michael J. LaPenta, M.D. 600 Ridgley Avenue Annapolis, MD 21401 (410-224-0070)							
31. DATE FILED (Month, Day, Year) NOV 1 1994				32. REGISTRAR'S SIGNATURE <i>Julia Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit form to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Amended # 196

10/27/94

MRT


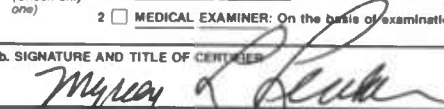

Montgomery City

94 33521

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Goldie Mary Darcey				2. DATE OF DEATH MONTH DAY YEAR October 21, 1994		3. TIME OF DEATH 6:30 a M					
4. SOCIAL SECURITY NUMBER 577-05-5535		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 94 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 26, 1900		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) Potomac Valley Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Rockville			9c. COUNTY OF DEATH Montgomery				
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Bethesda			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				
10e. STREET AND NUMBER 5511 Southwick Street				10f. ZIP CODE 20817		10g. CITIZEN OF WHAT COUNTRY? United States					
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 8 College (1-4 or 5+) 8				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Head Cashier			16b. KIND OF BUSINESS/INDUSTRY Raleighs				
17. FATHER'S NAME (First, Middle, Last) William J. Darcey				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ada Blundon							
19a. INFORMANT'S NAME (Type/Print) M. Elizabeth Broadhurst				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17300 Oakdale St., Rockville, MD 20853 5507 Southwick Street Bethesda, Maryland 20817							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parklawn Memorial Park October 25, 1994			20c. LOCATION — City or Town, State Rockville, Maryland						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  M00335				22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>aspiration pneumonia</u> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____								Approximate Interval Between Onset and Death 48h			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Arteriosclerotic Heart Disease</u>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER 						29c. LICENSE NUMBER 006674		29d. DATE SIGNED (Month, Day, Year) October 21, 1994			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Myron L. Lenkin M.D. 2309 Shorefield Road Wheaton, Maryland 20902-1825											
31. DATE FILED (Month, Day, Year) OCT 27 1994				32. REGISTRAR'S SIGNATURE 							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

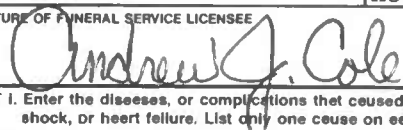
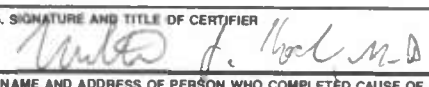
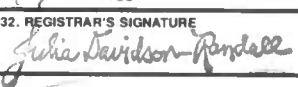
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33522

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) TERRENCE DOYLE				2. DATE OF DEATH MONTH DAY YEAR OCTOBER 22, 1994		3. TIME OF DEATH 10:10 P M	
4. SOCIAL SECURITY NUMBER 146-14-7057		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 68 YRS.		7. DATE OF BIRTH (Month, Day, Year) 1926 January 28,	
8. BIRTHPLACE (State or Foreign Country) New Jersey				9a. FACILITY NAME (If not institution, give street and number) 1733 Metzerott Road		9b. CITY, TOWN OR LOCATION OF DEATH Adelphi	
9c. COUNTY OF DEATH Prince George's				10a. STATE Maryland		10b. COUNTY Prince George's	
10c. CITY, TOWN OR LOCATION Adelphi				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 1733 Metzerott Road	
10f. ZIP CODE 20783				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5+		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Priest		16b. KIND OF BUSINESS/INDUSTRY Religion			
17. FATHER'S NAME (First, Middle, Last) Gregory Benedict Doyle				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Ewald			
19a. INFORMANT'S NAME (Type/Print) Father Robert M. Shay, S.T.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1733 Metzerott Road Adelphi, Maryland 20783			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Holy Trinity Cemetery 10/27/94		20c. LOCATION — City or Town, State Ft. Mitchell, Alabama		20d. DATE 10/27/94	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → pancreatic cancer DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death weeks
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED					
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER 014609		29d. DATE SIGNED (Month, Day, Year) 10/25/94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MILTON J. KOFF, M.D. 2121 MEDICAL PARK DR. S.E. MD 20902							
31. DATE FILED (Month, Day, Year) OCT 25 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33523

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Madeline June DuBois				2. DATE OF DEATH MONTH DAY YEAR October 21, 1994		3. TIME OF DEATH 10:08 P M	
4. SOCIAL SECURITY NUMBER 579-20-7462		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 70 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 28, 1924	
9a. FACILITY NAME (If not institution, give street and number) 6606 Stockton Lane				9b. CITY, TOWN OR LOCATION OF DEATH Hyattsville		9c. COUNTY OF DEATH Prince George's	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Hyattsville		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 6606 Stockton Lane				10f. ZIP CODE 20784		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home	
17. FATHER'S NAME (First, Middle, Last) Guy Hartman				16. MOTHER'S NAME (First, Middle, Maiden Surname) Pauline Louise Harris			
19a. INFORMANT'S NAME (Type/Print) Nancy R. Calebaugh				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 Q Southway Road, Greenbelt, Maryland 20770			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Metropolitan Crematory 10/23/94		DATE 10/23/94		20c. LOCATION — City or Town, State Alexandria, Virginia	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jack D. Friend</i>				22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE CARDIO-PULMONARY FAILURE DUE TO (OR AS A CONSEQUENCE OF): b. ACUTE MYELOMONOCYTIC LEUKEMIA DUE TO (OR AS A CONSEQUENCE OF): c. — DUE TO (OR AS A CONSEQUENCE OF): d. — Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death 30 Mins 2 weeks
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MITRAL VALVE REPLACEMENT ON COUMADIN							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John Harvey MD</i>				29c. LICENSE NUMBER D33053		29d. DATE SIGNED (Month, Day, Year) 10-22-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) OCT 25 1994				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33524

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JUNE FERN DAVIS				2. DATE OF DEATH MONTH 10 DAY 22 YEAR 94		3. TIME OF DEATH 1050 a m	
4. SOCIAL SECURITY NUMBER 201 18 9279		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) 6 23 1920	
8. BIRTHPLACE (State or Foreign Country) Kentucky		9a. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL ASSOCIATION		9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE		9c. COUNTY OF DEATH AA COUNTY	
10a. STATE Maryland		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Glen Burnie		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 7885 Gordon Court				10f. ZIP CODE 21061		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES No		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: No		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Waitress		16b. KIND OF BUSINESS/INDUSTRY Food Service			
17. FATHER'S NAME (First, Middle, Last) Rayne Mullins				18. MOTHER'S NAME (First, Middle, Maiden Surname) Emma Adams			
19a. INFORMANT'S NAME (Type/Print) Christina Crawford				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8065 Green Orchard Rd. Glen Burnie Md. 21061			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Loudon Park Cemetery 10/25/94		20c. LOCATION — City or Town, State Balt. Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert E. Evans Pres				22. NAME AND ADDRESS OF FACILITY Beall-Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Md. 20715			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <div style="border: 1px solid black; padding: 5px; margin: 5px;"> <p>Mixedema</p> <p>White renal failure</p> <p>Coronary artery disease</p> <p>Hypertension</p> </div>							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Morbidity Obesity							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER J. Ramirez		29c. LICENSE NUMBER D36256		29d. DATE SIGNED (Month, Day, Year) 10/22/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR RAMIREZ, JORGE M., M.D. 7845 OAKWOOD RD #205 GLEN BURNIE, MD 21061							
31. DATE FILED (Month, Day, Year) OCT 25 1994				32. REGISTRAR'S SIGNATURE John Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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NOV 11 1964

NOV 11 1964

94 33525

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Michael Gordon Danbury				2. DATE OF DEATH MONTH DAY YEAR OCT 18 1994		3. TIME OF DEATH 1:40 A.M.	
4. SOCIAL SECURITY NUMBER 216-04-7529		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 19 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov 8, 1974	
8. BIRTHPLACE (State or Foreign Country) Washington DC				9a. FACILITY NAME (If not institution, give street and number) 11007 Hollaway Drive		9b. CITY, TOWN OR LOCATION OF DEATH Upper Marlboro	
9c. COUNTY OF DEATH Prince George's				10a. STATE Maryland		10b. COUNTY Prince George's	
10c. CITY, TOWN OR LOCATION Upper Marlboro				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 11007 Hollaway Drive	
10f. ZIP CODE 20772				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Student		16b. KIND OF BUSINESS/INDUSTRY Prince George College	
17. FATHER'S NAME (First, Middle, Last) Donald H. Danbury				18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret A. Schauer			
19a. INFORMANT'S NAME (Type/Print) Donald Danbury (Father)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11007 Hollaway Drive, Upper Marlboro, Maryland 20772			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Resurrection Cemetery Oct 20, 94		20c. LOCATION — City or Town, State Clitno, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Stanley E. Morsels Jr.</i>				22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc 6633 Old Alexander Ferry Road, Clinton, Maryland 20735			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Myocardial infarction</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.				Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Alfonso Valle M.D.</i>			
29c. LICENSE NUMBER D12879				29d. DATE SIGNED (Month, Day, Year) OCT 19 1994			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ALFONSO VALLE M.D., 10701 TRAFORD DR., LARGO, MD 20772							
31. DATE FILED (Month, Day, Year) OCT 25 1994				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33526

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) OTHO F. DYER				2. DATE OF DEATH MONTH DAY YEAR 10 26 94		3. TIME OF DEATH 18:45 PM	
4. SOCIAL SECURITY NUMBER 705-05-8573		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 92 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) May 26, 1902	
8a. FACILITY NAME (If not institution, give street and number) MEMORIAL HOSPITAL & MED. CTR.				8b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND, MD		8c. COUNTY OF DEATH ALLEGANY	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY Allegany		10c. CITY, TOWN OR LOCATION Cumberland		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 611 Columbia Avenue				10f. ZIP CODE 21502		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Retired Yard Master		16b. KIND OF BUSINESS/INDUSTRY Railroad	
17. FATHER'S NAME (First, Middle, Last) Joseph Early Dyer				18. MOTHER'S NAME (First, Middle, Maiden Surname) Amanda (Harshman)			
19a. INFORMANT'S NAME (Type/Print) Anita Salesky				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Route 2 Box 613A; Ridgeley, WV 26753			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Ashby Cemetery		OATE 10/30		20c. LOCATION — City or Town, State Fort Ashby, WV	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE James F. Scarpelli				22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Small Bull struck Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER DR. VIK POONAI				29c. LICENSE NUMBER D 36766		29d. DATE SIGNED (Month, Day, Year) 10/28/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. VIK POONAI, 455 FREDERICK STREET, CUMBERLAND, MD 21502							
31. DATE FILED (Month, Day, Year) OCT 27 1994				32. REGISTRAR'S SIGNATURE John J. ...			

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

94 33527

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Yizhi Deng				2. DATE OF DEATH MONTH November DAY 7 YEAR 1994				3. TIME OF DEATH 4:45 AM	
4. SOCIAL SECURITY NUMBER 622-50-3043		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 25 YRS.		7. DATE OF BIRTH (Month, Day, Year) 2 16 69		8. BIRTHPLACE (State or Foreign Country) REPUBLIC of CHINA	
9a. FACILITY NAME (If not institution, give street and number) Union Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City				9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT									
10a. STATE MD		10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 14 W. COLD SPRING LANE APT 605				10f. ZIP CODE 21211		10g. CITIZEN OF WHAT COUNTRY? REPUBLIC of CHINA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: ORIENTAL			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY OWN HOME			
17. FATHER'S NAME (First, Middle, Last) YU DONG DENG				18. MOTHER'S NAME (First, Middle, Maiden Surname) JUZHAO XIE					
19a. INFORMANT'S NAME (Type/Print) JAMES GANN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 207 ATHOL GATE LANE APT D BALTO MD 21229					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DULANEY VALLEY 11/10		20c. LOCATION — City or Town, State BALTO. MD.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY DELLA NOLE + SONS Funeral Home 322 S. HIGH ST. BALTO 21202 MD.					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory Arrest DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. metabolic acidosis DUE TO (OR AS A CONSEQUENCE OF): c. peripheral neurocutaneous tumor DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate interval Between Onset and Death 15 minutes 12 hr 1 yr	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD				29c. LICENSE NUMBER AT2438946		29d. DATE SIGNED (Month, Day, Year) November 7, 1994			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SAMUEL MALLER Union Memorial Hosp									
31. DATE FILED (Month, Day, Year) NOV 18 1994				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician for use as a burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached by use as a burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33528

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HELEN HOLLINSHEAD DIETTERICH				2. DATE OF DEATH MONTH DAY YEAR NOV. 10, 1994		3. TIME OF DEATH 6:25 A M	
4. SOCIAL SECURITY NUMBER 485-40-6894		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 93 YRS.		7. DATE OF BIRTH (Month, Day, Year) OCT. 2, 1901	
8. BIRTHPLACE (State or Foreign Country) OHIO				9a. FACILITY NAME (If not institution, give street and number) WILSON HEALTH CARE CENTER		9b. CITY, TOWN OR LOCATION OF DEATH GAITHERSBURG	
9c. COUNTY OF DEATH MONTGOMERY							
RESIDENCE OF DECEDENT							
10a. STATE MD.		10b. COUNTY MONTGOMERY		10c. CITY, TOWN OR LOCATION GAITHERSBURG		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 401 RUSSELL AVENUE				10f. ZIP CODE 20877		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— if yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER		16b. KIND OF BUSINESS/INDUSTRY HOME			
17. FATHER'S NAME (First, Middle, Last) LESTER H. HOLLINSHEAD				18. MOTHER'S NAME (First, Middle, Maiden Surname) ANGIE SMITH			
19a. INFORMANT'S NAME (Type/Print) PAUL M. DIETTERICH				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5201 S. CORNELL AVENUE CHICAGO, ILLINOIS 60615			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) METROPOLITAN CREMATORY		20c. DATE 11/11		20d. LOCATION — City or Town, State ALEXANDRIA, VA.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Muriel H. Barber				22. NAME AND ADDRESS OF FACILITY MURIEL H. BARBER FUNERAL HOME 20882 P.O. BOX 5038 LAYTONSVILLE, MARYLAND			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cerebral Thrombosis							
b. Cerebral Arteriosclerosis							
c. —							
d. —							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER James R. Moore, MD				29c. LICENSE NUMBER 07231		29d. DATE SIGNED (Month, Day, Year) Nov 10, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) James R. Moore, Jr. 207 Brookside Ave Gaithersburg MD 20878							
31. DATE FILED (Month, Day, Year) NOV 16 1994				32. REGISTRAR'S SIGNATURE John A. ...			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that every entry must be supported by proper documentation, such as receipts or invoices, to ensure the integrity of the financial data.

2. The second part of the document outlines the procedures for reconciling bank statements with the company's internal records. It states that this process should be performed monthly to identify any discrepancies and correct them promptly.

3. The third part of the document describes the process for preparing the monthly financial statements. It includes a list of the required components, such as the balance sheet, income statement, and cash flow statement, and provides guidance on how to format and present this information.

4. The fourth part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that every entry must be supported by proper documentation, such as receipts or invoices, to ensure the integrity of the financial data.

5. The fifth part of the document outlines the procedures for reconciling bank statements with the company's internal records. It states that this process should be performed monthly to identify any discrepancies and correct them promptly.

6. The sixth part of the document describes the process for preparing the monthly financial statements. It includes a list of the required components, such as the balance sheet, income statement, and cash flow statement, and provides guidance on how to format and present this information.

7. The seventh part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that every entry must be supported by proper documentation, such as receipts or invoices, to ensure the integrity of the financial data.

8. The eighth part of the document outlines the procedures for reconciling bank statements with the company's internal records. It states that this process should be performed monthly to identify any discrepancies and correct them promptly.

9. The ninth part of the document describes the process for preparing the monthly financial statements. It includes a list of the required components, such as the balance sheet, income statement, and cash flow statement, and provides guidance on how to format and present this information.

10. The tenth part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that every entry must be supported by proper documentation, such as receipts or invoices, to ensure the integrity of the financial data.

94 33529

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Darr Alice</i> ALICE DARR				2. DATE OF DEATH MONTH DAY YEAR <i>11/9/94</i>		3. TIME OF DEATH <i>1:45 A M</i>	
4. SOCIAL SECURITY NUMBER 215-20-8623		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 69 YRS.		7. DATE OF BIRTH (Month, Day, Year) 6/24/25	
8. BIRTHPLACE (State or Foreign Country) Virginia				9a. FACILITY NAME (If not institution, give street and number) 6808 Yellowsheve Court		9b. CITY, TOWN OR LOCATION OF DEATH Frederick	
9c. COUNTY OF DEATH Frederick				10a. STATE Maryland		10b. COUNTY Frederick	
10c. CITY, TOWN OR LOCATION XXXXXXXXXXXXXXXXXXXX Frederick				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 6808 Yellowsheve Court	
10f. ZIP CODE 21701				10g. CITIZEN OF WHAT COUNTRY? US of A		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Gov. Retired Printing/offi. Government		16b. KIND OF BUSINESS/INDUSTRY Government	
17. FATHER'S NAME (First, Middle, Last) Eugene W. Darr				18. MOTHER'S NAME (First, Middle, Maiden Surname) Daisey B. Hackley			
19a. INFORMANT'S NAME (Type/Print) Randy Darr - nephew				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3626 Glemoble Court, Jefferson, Maryland 21755			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Union Cemetery Nov. 11, 1994		20c. LOCATION — City or Town, State Lovettsville, Va.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>W. H. Smay</i>				22. NAME AND ADDRESS OF FACILITY Brown Funeral Home P.O. Box 320 Lovettsville, Virginia 22080			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>extensive coronary artery</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>with brain metastasis</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>biologic process</i>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <i>177622</i>		29d. DATE SIGNED (Month, Day, Year) <i>11/18/94</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) <i>501 West 7th Street Frederick Md 21701</i>							
31. DATE FILED (Month, Day, Year) <i>NOV 18 1994</i>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION




DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21213-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use by the funeral director. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33530

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Leonard Nimrod EMBLY, Sr.				2. DATE OF DEATH MONTH DAY YEAR October 31, 1994		3. TIME OF DEATH 8:38 AM	
4. SOCIAL SECURITY NUMBER 212-24-5481		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 66 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 26, 1928	
9a. FACILITY NAME (If not institution, give street and number) Washington County Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown		9c. COUNTY OF DEATH Washington	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Hagerstown		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 9732 Garis Shop Road				10f. ZIP CODE 21740		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) maintenance electrician		16b. KIND OF BUSINESS/INDUSTRY manufacturing			
17. FATHER'S NAME (First, Middle, Last) Leonard William Embly				18. MOTHER'S NAME (First, Middle, Maiden Surname) Dolly Elizabeth Jones			
19a. INFORMANT'S NAME (Type/Print) Beatrice Irene Embly				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9732 Garis Shop Road, Hagerstown, Maryland 21740			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Rest Haven Cemetery 11-3-94		DATE 11-3-94		20c. LOCATION — City or Town, State Hagerstown, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): b. due to Ischemic Cardiomyopathy DUE TO (OR AS A CONSEQUENCE OF): c. and NonHodgkin's Lymphoma DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death months 4-5 years 4-5 years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> XER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D01062		29d. DATE SIGNED (Month, Day, Year) November 1, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Edward W. Ditto, III, M.D. 217 W. Washington St. Hagerstown, Md. 21740							
31. DATE FILED (Month, Day, Year) NOV 02 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Easterling Derrick

94 33531

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) DERICK W EASTERLING		2. DATE OF DEATH MONTH DAY YEAR OCTOBER 14 1994		3. TIME OF DEATH 8:30 A M	
4. SOCIAL SECURITY NUMBER 577-86-6164		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 35 YRS.	
7. DATE OF BIRTH (Month, Day, Year) APRIL 17, 1959		8. BIRTHPLACE (State or Foreign Country) WASHINGTON, D.C.		9. COUNTY OF DEATH PRINCE GEORGES	
9a. FACILITY NAME (If not institution, give street and number) Southern Maryland Hospital Center		9b. CITY, TOWN OR LOCATION OF DEATH CLINTON		9c. COUNTY OF DEATH PRINCE GEORGES	
10a. STATE N/A		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION WASHINGTON, D.C.	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 414 RITTENHOUSE STREET, N.W.		10f. ZIP CODE 20011	
10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4 or 5+) College (1-4 or 5+)	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LABOR		16b. KIND OF BUSINESS/INDUSTRY PRIVATE		17. FATHER'S NAME (First, Middle, Last) GRANT B. EASTERLING	
18. MOTHER'S NAME (First, Middle, Maiden Surname) ALICE GARNETT EASTERLING		19a. INFORMANT'S NAME (Type/Print) GRANT B. EASTERLING (FATHER)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 414 RITTENHOUSE STREET, N.W.: WASHINGTON, D.C.	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) FORT LINCOLN CEMETERY 10/21/94 BRENTWOOD, MARYLAND		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Jordan Freeman		22. NAME AND ADDRESS OF FACILITY JOHNSON & JENKINS FUNERAL HOME, INC. 716 KENNEDY STREET, N.W.: WDC 20011		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → AIDS DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST Dehydration - Renal Failure - Anemia	
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO		25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) 10-14-94	
28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER Sam Tellaoui		29c. LICENSE NUMBER D34274		29d. DATE SIGNED (Month, Day, Year) 10-14-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ESSAM TELLAWI, M.D. 7700 OLD BRANCH AVENUE, CLINTON, MARYLAND 20735		31. DATE FILED (Month, Day, Year) OCT 25 1994		32. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) VAL NORDGREN ESHLEMAN				2. DATE OF DEATH MONTH DAY YEAR OCT 27 1994		3. TIME OF DEATH 9:55 A.M.	
4. SOCIAL SECURITY NUMBER 212-78-2370		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 35 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb 9 1959	
8. BIRTHPLACE (State or Foreign Country) Maryland				9. COUNTY OF DEATH BALTIMORE CITY			
9a. FACILITY NAME (If not institution, give street and number) UNIVERSITY S.T.U.				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY			
10a. STATE MD		10b. COUNTY Queen Anne		10c. CITY, TOWN OR LOCATION Stevensville		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 1000 Kentmorr Road				10f. ZIP CODE 21666		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) General Manager		16b. KIND OF BUSINESS/INDUSTRY Yacht Yard/Marina			
17. FATHER'S NAME (First, Middle, Last) James Edward Eshleman				18. MOTHER'S NAME (First, Middle, Maiden Surname) Marilyn Skell			
19a. INFORMANT'S NAME (Type/Print) Paula E. Eshleman				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1000 Kentmorr Road Stevensville, Maryland 21666			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Lincoln Crematory 10/29/94		20c. LOCATION — City or Town, State Brentwood, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donald S. Taylor</i>				22. NAME AND ADDRESS OF FACILITY John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. <u>Electrocution</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 10-27-94		28b. TIME OF INJURY 0845M		28c. INJURY AT WORK? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED Subject electrocuted		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Marina		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 107 Eastern Ave Annapolis	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>David R. Fowler</i>				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) OCT 28, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David R. Fowler 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) NOV 1 1994		32. REGISTRAR'S SIGNATURE <i>Jane Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Amended #1 10/24/94 MRT Montgomery Cty. 94 33533

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) James E. Francis				2. DATE OF DEATH MONTH DAY YEAR OCTOBER 9 94		3. TIME OF DEATH 5:58 PM						
4. SOCIAL SECURITY NUMBER 215-14-6096		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 31, 1921		8. BIRTHPLACE (State or Foreign Country) Maryland				
9a. FACILITY NAME (If not institution, give street and number) Washington Adventist Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Takoma Park			9c. COUNTY OF DEATH Montgomery					
10a. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION College Park			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER 5803 Goucher Drive				10f. ZIP CODE 20740		10g. CITIZEN OF WHAT COUNTRY? USA						
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White						
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Accountant Auditor		16b. KIND OF BUSINESS/INDUSTRY D.C. Government								
17. FATHER'S NAME (First, Middle, Last) James Francis				18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth Izat								
19a. INFORMANT'S NAME (Type/Print) Betty B. Francis				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5803 Goucher Drive College Park, MD 20740								
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Cemetery 10/22/94		20c. LOCATION — City or Town, State Brentwood, Maryland								
21. SIGNATURE OF FUNERAL SERVICE LICENSEE James S. Dooly				22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901								
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic Rhabdomyosarcoma DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate interval Between Onset and Death 1 year					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cardiovascular Disease Fever of Neutropenia							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED				
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)								
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							29b. SIGNATURE AND TITLE OF CERTIFIER Clara Chan, M.D.		29c. LICENSE NUMBER D41828		29d. DATE SIGNED (Month/Day/Year) 10/19/1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CLARA CHAN, M.D. 7525 Greenway Center Dr. Greenbelt, MD 20770												
31. DATE FILED (Month, Day, Year) OCT 24 1994		32. REGISTRAR'S SIGNATURE Jane Davidson-Randall										

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33534

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Frank Forte				2. DATE OF DEATH MONTH DAY YEAR October 23 1994		3. TIME OF DEATH 5:15 P.M.	
4. SOCIAL SECURITY NUMBER 146-22-4743		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 82 YRS.		7. DATE OF BIRTH (Month, Day, Year) December 23, 1911	
9a. FACILITY NAME (If not institution, give street and number) Shady Grove Adventist Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Rockville		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland				10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Montgomery Village	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 20505 Oak Bluff Drive			
10f. ZIP CODE 20879				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Mechanic		16b. KIND OF BUSINESS/INDUSTRY Automobile	
17. FATHER'S NAME (First, Middle, Last) Frank Forte				18. MOTHER'S NAME (First, Middle, Maiden Surname) Rosa DeMartini			
19a. INFORMANT'S NAME (Type/Print) Mary Louise Forte				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20505 Oak Bluff Drive Montgomery Village, Maryland 20879			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 10/27/94		20c. LOCATION — City or Town, State Silver Spring, Maryland		21. SIGNATURE OF FUNERAL SERVICE LICENSEE James E. Dooly	
22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → END STAGE Renal Disease Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Multiple Myeloma Hypertension					
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Dr. M.D.				29c. LICENSE NUMBER D2675		29d. DATE SIGNED (Month, Day, Year) 10/24/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. V. Boccia MD 14808 Physicians W #12 Rockville, MD							
31. DATE FILED (Month, Day, Year) OCT 27 1994				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Amended #206

10/27/94

MRT

Montgomery Cty.

94 33535

1 -
FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Rose B Franko				2. DATE OF DEATH MONTH DAY YEAR Oct. 22 94		3. TIME OF DEATH 1130 P. M	
4. SOCIAL SECURITY NUMBER 287-16-0163		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 82 YRS.	7. DATE OF BIRTH (Month, Day, Year) April 19, 1912		8. BIRTHPLACE (State or Foreign Country) Ohio	
9a. FACILITY NAME (If not institution, give street and number) Suburban Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Bethesda		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Rockville		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 14635 Bauer Drive, #308				10f. ZIP CODE 20853		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Clerk		16b. KIND OF BUSINESS/INDUSTRY Sears			
17. FATHER'S NAME (First, Middle, Last) Joseph Bartak				18. MOTHER'S NAME (First, Middle, Maiden Surname) Jennie Pleschmidt			
19a. INFORMANT'S NAME (Type/Print) Marilyn McNichol				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4310 Merton Road, Rockville, Maryland 20853			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Patrick Gate of Heaven 10/27/94 DATE		20c. LOCATION — City or Town, State Silver Spring, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Michelle P. Kette M00348				22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Rockville, Inc., 300 W. Montgomery Ave Rockville, Maryland 20850-2805			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. medietate adeno Carcinoma DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate interval Between Onset and Death 3 mo	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pulmonary Edema Hypertensive heart disease						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Jeremy V. Cooke		29c. LICENSE NUMBER D04602		29d. DATE SIGNED (Month, Day, Year) 10-25-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Jeremy V. Cooke MD, 10400 Conn. Ave, Kensington, Md 20891							
31. DATE FILED (Month, Day, Year) OCT 27 1994				32. REGISTRAR'S SIGNATURE John Davidson-Randall			

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

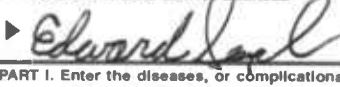

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

94 33536

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Martin Fogel				2. DATE OF DEATH MONTH October DAY 26 YEAR 1994		3. TIME OF DEATH 2212 P M	
4. SOCIAL SECURITY NUMBER 577-46-2931		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 61 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 30, 1933	
8. BIRTHPLACE (State or Foreign Country) New York		9a. FACILITY NAME (If not institution, give street and number) Shady Grove Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Rockville		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Potomac		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 11729 Trail Ridge Drive				10f. ZIP CODE 20854		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Business Consultant		16b. KIND OF BUSINESS/INDUSTRY General Business			
17. FATHER'S NAME (First, Middle, Last) Samuel Fogel				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mariam Betty Opalek			
19a. INFORMANT'S NAME (Type/Print) Myrna Fogel				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11729 Trail Ridge Drive, Potomac, MD 20854			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Judean Memorial Gardens		DATE 10/28		20c. LOCATION — City or Town, State Olney, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Edward Sagel Funeral Direction 1091 Rockville Pike, Rockville, MD 20852			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Rupture of Myocardium					Approximate Interval Between Onset and Death mins
		b. Myocardial Infarction					6 hrs.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		c. Diabetes Mellitus					12 years
		d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED					
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Michael R. B. [Signature], M.D.				29c. LICENSE NUMBER A243204		29d. DATE SIGNED (Month, Day, Year) October 27, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 19231 Montgomery Village Ave D-1 Gaithersburg, MD 20879							
31. DATE FILED (Month, Day, Year) OCT 28 1994		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

7

94 33537

Amended #6, 10/27/94

MRT

Montgomery Cty.

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>ESSIE R. Frye</i>				2. DATE OF DEATH MONTH <i>Oct</i> DAY <i>18</i> YEAR <i>94</i>		3. TIME OF DEATH <i>3:51 P M</i>	
4. SOCIAL SECURITY NUMBER Unavailable		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <i>86</i> YRS.	7. DATE OF BIRTH (Month, Day, Year) Oct. 31, 1907	8. BIRTHPLACE (State or Foreign Country) West Virginia		
9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 12111 Veirs Mill				10f. ZIP CODE 20906		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (10-12) <i>8</i> College (1-4 or 5+) <i>8</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Home			
17. FATHER'S NAME (First, Middle, Last) Benjamin Webster				18. MOTHER'S NAME (First, Middle, Maiden Surname) Savana Mauck			
19a. INFORMANT'S NAME (Type/Print) Charles L. Wilson (son)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandy Springs, Maryland 20860			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Wardensville Cemetery 10/22		20c. LOCATION — City or Town, State Wardensville, WV			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>David L. Savers</i>				22. NAME AND ADDRESS OF FACILITY Capitol Funeral Service, Falls Church, VA			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Myocardial Infarction</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Arteriosclerotic heart disease</i> PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic Obstructive Pulmonary Disease</i>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>David L. Savers</i>				29c. LICENSE NUMBER <i>DD2421</i>		29d. DATE SIGNED (Month, Day, Year) <i>18 Oct 94</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) <i>OCT 27 1994</i>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit certificate and filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

Amended #1 10/24/94 MRT Montgomery City 94 33538

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ROSANNA ELIZABETH FORMICA		2. DATE OF DEATH MONTH 10 - DAY 23 - YEAR 94		3. TIME OF DEATH 0250 AM
4. SOCIAL SECURITY NUMBER 042-03-8593	5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 83 YRS.	7. DATE OF BIRTH (Month, Day, Year) APRIL 23, 1911	8. BIRTHPLACE (State or Foreign Country) MAINE
9a. FACILITY NAME (If not institution, give street and number) WASHINGTON ADVENTIST HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH TAKOMA PARK		9c. COUNTY OF DEATH MONTGOMERY
RESIDENCE OF DECEDENT				
10a. STATE MARYLAND	10b. COUNTY MONTGOMERY	10c. CITY, TOWN OR LOCATION KENSINGTON		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
10e. STREET AND NUMBER 3210 FERNDAL STREET		10f. ZIP CODE 20895	10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) HOMEMAKER		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) OWN HOME		14. RACE — American Indian, Black, White, etc. Specify: WHITE
17. FATHER'S NAME (First, Middle, Last) AUGUSTE MADORE		18. MOTHER'S NAME (First, Middle, Maiden Surname) MODESTE MICHAUD		
19a. INFORMANT'S NAME (Type/Print) THEODORE S. FORMICA		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3210 FERNDAL STREET, KENSINGTON, MARYLAND 20895		
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) METROPOLITAN CREMATORY 10/23/94		20c. LOCATION — City or Town, State ALEXANDRIA, VIRGINIA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Steven D. Stord		22. NAME AND ADDRESS OF FACILITY FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W., SIL. SP., MD 20901		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):				Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. SIGNATURE AND TITLE OF CERTIFIER Mark Allen Mazer MD		29c. LICENSE NUMBER D36704		29d. DATE SIGNED (Month, Day, Year) 10/23/94
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mark MAZER MD Washington Adventist Hospital Takoma Park MD				
31. DATE FILED (Month, Day, Year) OCT 24 1994		32. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

5

THE CITY OF BOSTON

OFFICE OF THE CITY CLERK

4pm 10/25/94

94 33539

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ELEANOR LEE FLETCHER				2. DATE OF DEATH MONTH DAY YEAR October 25, 1994		3. TIME OF DEATH 4:00 P M	
4. SOCIAL SECURITY NUMBER 579-01-3249		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 87 YRS.		7. DATE OF BIRTH (Month, Day, Year) Mar. 25, 1907	
9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION College Park		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 9014 Rhode Island Avenue				10f. ZIP CODE 20740		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Samuel Cochran				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lula C. Kern			
19a. INFORMANT'S NAME (Type/Print) Nancy Winslow				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12717 Northcliff Road, Bowie, Maryland 20720			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Cemetery 10/29/94		20c. LOCATION — City or Town, State Brentwood, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE W. B. Geiser				22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory Arrest DUE TO (OR AS A CONSEQUENCE OF): b. CHF DUE TO (OR AS A CONSEQUENCE OF): c. Pancreatic Cancer DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death minutes days months
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pancreatic Cancer							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Robert C. Finkel MD		29c. LICENSE NUMBER 043414		29d. DATE SIGNED (Month, Day, Year) 10/25/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert C. Finkel MD 1106 Spring St Silver Spring MD							
31. DATE FILED (Month, Day, Year) OCT 28 1994		32. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33541

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CELESTA AGNES FREELAND				2. DATE OF DEATH MONTH 10 DAY 27 YEAR 94		3. TIME OF DEATH 19:15P M	
4. SOCIAL SECURITY NUMBER 217-10-7719		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 81 YRS.		7. DATE OF BIRTH (Month, Day, Year) SEPT 4 1913	
8. BIRTHPLACE (State or Foreign Country) W.VA.				9a. FACILITY NAME (If not institution, give street and number) MEMORIAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND	
9c. COUNTY OF DEATH ALLEGANY				10a. STATE MARYLAND		10b. COUNTY ALLEGANY	
10c. CITY, TOWN OR LOCATION CUMBERLAND				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 425 PENNSYLVANIA AVE.	
10f. ZIP CODE 21502				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) CELENASE CORP OF AMERICA				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SILK/ MANUF		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) LUGI ROSO				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARGARITE (UNK)			
19a. INFORMANT'S NAME (Type/Print) PAUL EDWARD FREELAND				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 425 PENNSYLVANIA AVE CUMBERLAND MARYLAND 21502			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cumberland CREMATORY OCT 28 1994 CUMBERLAND MARYLAND		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dale L. Merritt</i>				22. NAME AND ADDRESS OF FACILITY MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>myocardial infarction</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dale L. Merritt</i>				29c. LICENSE NUMBER D 36766		29d. DATE SIGNED (Month, Day, Year) 10/28/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. VIK POONAI, 155 Frederick St., Cumberland, MD 21502							
31. DATE FILED (Month, Day, Year) OCT 28 1994				32. REGISTRAR'S SIGNATURE <i>Dale L. Merritt</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760



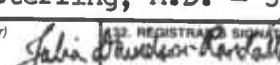
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33542

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) BETTY RAE FRANKLIN				2. DATE OF DEATH MONTH November DAY 2 YEAR 1994				3. TIME OF DEATH 9:05 P M	
4. SOCIAL SECURITY NUMBER 218-14-4005		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 69 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 26, 1924		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) 3 Standard Ave. (Home)				9b. CITY, TOWN OR LOCATION OF DEATH Crisfield				9c. COUNTY OF DEATH Somerset	
RESIDENCE OF DECEDENT									
10a. STATE Maryland		10b. COUNTY Somerset		10c. CITY, TOWN OR LOCATION Crisfield				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 3 Standard Ave.				10f. ZIP CODE 21817		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Grade 7 College (1-4 or 5+) — — —				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Seamstress				16b. KIND OF BUSINESS/INDUSTRY Garment Manufacturing	
17. FATHER'S NAME (First, Middle, Last) William B. Franklin				18. MOTHER'S NAME (First, Middle, Maiden Surname) Merrible Parker					
19a. INFORMANT'S NAME (Type/Print) (sister-in-law) Fay M. Franklin				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Standard Ave. - Crisfield, MD 21817					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Sunnyridge Memorial Park 11/5/94 Crisfield, MD				20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  Robert H. Bradshaw				22. NAME AND ADDRESS OF FACILITY Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, MD 21817					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → RENAL FAILURE a. DUE TO (OR AS A CONSEQUENCE OF): DIABETES b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death 2 YEARS YEARS	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
				28d. DESCRIBE HOW INJURY OCCURRED					
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)					
				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER  James A. Sterling, M.D.				29c. LICENSE NUMBER D 10214				29d. DATE SIGNED (Month, Day, Year) 11/03/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) James A. Sterling, M.D. - 320 W. Main St. - Crisfield, MD 21817									
31. DATE FILED (Month, Day, Year) NOV 04 1994				32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. TO BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPT. OF HEALTH AND MENTAL HYGIENE PRIOR TO BURIAL, CREMATION, OR REMOVAL.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33543

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARGARETTA FORBES		2. DATE OF DEATH 70 30 94		3. TIME OF DEATH 0115	
4. SOCIAL SECURITY NUMBER 217-28-1917		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (in yrs. last birthday) 86 YRS.	
7. DATE OF BIRTH (Month, Day, Year) Oct 11 1908		8. BIRTHPLACE (State or Foreign Country) Pennsylvania			
9a. FACILITY NAME (If not institution, give street and number) 700 Americana Drive Apt A-2		9b. CITY, TOWN OR LOCATION OF DEATH Annapolis		9c. COUNTY OF DEATH Anne Arundel	
10a. STATE MD		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Annapolis	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 700 Americana Drive Apt A-2		10f. ZIP CODE 21403	
10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Administrative Aide		16b. KIND OF BUSINESS/INDUSTRY U.S. Government	
17. FATHER'S NAME (First, Middle, Last) Edward A. Shriver		18. MOTHER'S NAME (First, Middle, Maiden Surname) M. Margaret Ripple			
19a. INFORMANT'S NAME (Type/Print) James D. Forbes		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 700 Americana Drive Apt A-2 Annapolis, Maryland 21403			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) F. Lincoln Crematory 10/31/94		20c. LOCATION — City or Town, State Brentwood, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donald S. Lyster</i>		22. NAME AND ADDRESS OF FACILITY John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → C.V.A. Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Age					Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Age					24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Michael J. LaPenta</i>		29c. LICENSE NUMBER 021438		29d. DATE SIGNED (Month, Day, Year) 10/30/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) MICHAEL J. LaPenta, 600 RIDGELY AVE ANNAPOLIS MD 21401					
31. DATE FILED (Month, Day, Year) NOV 1 1994		32. REGISTRAR'S SIGNATURE <i>Julia Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, and in by the funeral director, page 5 should be detached for use as the burial certificate. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33544

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) James M. Ferrell				2. DATE OF DEATH MONTH DAY YEAR October 20 1994		3. TIME OF DEATH 7:00A M	
4. SOCIAL SECURITY NUMBER 226-16-2820		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 81 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept 13 1913	
9a. FACILITY NAME (If not institution, give street and number) 1776 Dunton Road				9b. CITY, TOWN OR LOCATION OF DEATH Annapolis		9c. COUNTY OF DEATH Anne Arundel	
RESIDENCE OF DECEDENT							
10a. STATE VA		10b. COUNTY Halifax		10c. CITY, TOWN OR LOCATION Clover		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER Route 1 Box 225				10f. ZIP CODE 24534		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Carpenter		16b. KIND OF BUSINESS/INDUSTRY Cabinetry	
17. FATHER'S NAME (First, Middle, Last) John H. Ferrell				18. MOTHER'S NAME (First, Middle, Maiden Surname) Hattie Moorefield			
19a. INFORMANT'S NAME (Type/Print) Barbara Ferrell				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Route 1 Box 225 Clover, Virginia 24534			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Maryland Veteran Cemetery 11/2/94		20c. LOCATION — City or Town, State Crownsville, Maryland		20d. NAME AND ADDRESS OF FACILITY John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donald A. Lupton</i>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Dementia 298.9							
Due to (or as a consequence of):							
b. Brain syndrome, chronic organic 310.9							
Due to (or as a consequence of):							
c. —							
Due to (or as a consequence of):							
d. —							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alcoholism 303.9							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Assisted living home					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Nonlethal 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Charles W. Kinzer, M.D.				29c. LICENSE NUMBER D05928		29d. DATE SIGNED (Month, Day, Year) October 31, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Charles W. Kinzer, M.D. 1833-A Forbes Blvd. Annapolis, Maryland 21401							
31. DATE FILED (Month, Day, Year) NOV 1 1994				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.


TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Lillian Gale				2. DATE OF DEATH MONTH DAY YEAR October 25, 1994				3. TIME OF DEATH 5:30 P							
4. SOCIAL SECURITY NUMBER 087-20-9592		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 90 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Jan 13, 1904		8. BIRTHPLACE (State or Foreign Country) New York			
9a. FACILITY NAME (If not institution, give street and number) Arcola Nursing Home								9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring				9c. COUNTY OF DEATH Montgomery			
RESIDENCE OF DECEDENT															
10a. STATE Maryland		10b. COUNTY Montgomery				10c. CITY, TOWN OR LOCATION Silver Spring				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER 901 Arcola Avenue						10f. ZIP CODE 20902				10g. CITIZEN OF WHAT COUNTRY? United States					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Clerk				16b. KIND OF BUSINESS/INDUSTRY Aerospace							
17. FATHER'S NAME (First, Middle, Last) Joseph Lewis						18. MOTHER'S NAME (First, Middle, Maiden Surname) Rachael Marks									
19a. INFORMANT'S NAME (Type/Print) Sandra Seidel				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8524 Fox Run, Potomac, MD 20854											
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Temple Israel Cemetery				DATE 10-28		20c. LOCATION — City or Town, State Conklin, NY					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  MO0827				22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Alzheimer's dementia Sequitentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST e. Alzheimer's dementia f. Due to (or as a consequence of): g. Due to (or as a consequence of): h. Due to (or as a consequence of): i. Due to (or as a consequence of): j. Due to (or as a consequence of): k. Due to (or as a consequence of): l. Due to (or as a consequence of): m. Due to (or as a consequence of): n. Due to (or as a consequence of): o. Due to (or as a consequence of): p. Due to (or as a consequence of): q. Due to (or as a consequence of): r. Due to (or as a consequence of): s. Due to (or as a consequence of): t. Due to (or as a consequence of): u. Due to (or as a consequence of): v. Due to (or as a consequence of): w. Due to (or as a consequence of): x. Due to (or as a consequence of): y. Due to (or as a consequence of): z. Due to (or as a consequence of): aa. Due to (or as a consequence of): ab. Due to (or as a consequence of): ac. Due to (or as a consequence of): ad. Due to (or as a consequence of): ae. Due to (or as a consequence of): af. Due to (or as a consequence of): ag. Due to (or as a consequence of): ah. Due to (or as a consequence of): ai. Due to (or as a consequence of): aj. Due to (or as a consequence of): ak. Due to (or as a consequence of): al. Due to (or as a consequence of): am. Due to (or as a consequence of): an. Due to (or as a consequence of): ao. Due to (or as a consequence of): ap. Due to (or as a consequence of): aq. Due to (or as a consequence of): ar. Due to (or as a consequence of): as. Due to (or as a consequence of): at. Due to (or as a consequence of): au. Due to (or as a consequence of): av. Due to (or as a consequence of): aw. Due to (or as a consequence of): ax. Due to (or as a consequence of): ay. Due to (or as a consequence of): az. Due to (or as a consequence of): ba. Due to (or as a consequence of): bb. Due to (or as a consequence of): bc. Due to (or as a consequence of): bd. Due to (or as a consequence of): be. Due to (or as a consequence of): bf. Due to (or as a consequence of): bg. Due to (or as a consequence of): bh. Due to (or as a consequence of): bi. Due to (or as a consequence of): bj. Due to (or as a consequence of): bk. Due to (or as a consequence of): bl. Due to (or as a consequence of): bm. Due to (or as a consequence of): bn. Due to (or as a consequence of): bo. Due to (or as a consequence of): bp. Due to (or as a consequence of): bq. Due to (or as a consequence of): br. Due to (or as a consequence of): bs. Due to (or as a consequence of): bt. Due to (or as a consequence of): bu. Due to (or as a consequence of): bv. Due to (or as a consequence of): bw. Due to (or as a consequence of): bx. Due to (or as a consequence of): by. Due to (or as a consequence of): bz. Due to (or as a consequence of): ca. Due to (or as a consequence of): cb. Due to (or as a consequence of): cc. Due to (or as a consequence of): cd. Due to (or as a consequence of): ce. Due to (or as a consequence of): cf. Due to (or as a consequence of): cg. Due to (or as a consequence of): ch. Due to (or as a consequence of): ci. Due to (or as a consequence of): cj. Due to (or as a consequence of): ck. Due to (or as a consequence of): cl. Due to (or as a consequence of): cm. Due to (or as a consequence of): cn. Due to (or as a consequence of): co. Due to (or as a consequence of): cp. Due to (or as a consequence of): cq. Due to (or as a consequence of): cr. Due to (or as a consequence of): cs. Due to (or as a consequence of): ct. Due to (or as a consequence of): cu. Due to (or as a consequence of): cv. Due to (or as a consequence of): cw. Due to (or as a consequence of): cx. Due to (or as a consequence of): cy. Due to (or as a consequence of): cz. Due to (or as a consequence of): da. Due to (or as a consequence of): db. Due to (or as a consequence of): dc. Due to (or as a consequence of): dd. Due to (or as a consequence of): de. Due to (or as a consequence of): df. Due to (or as a consequence of): dg. Due to (or as a consequence of): dh. Due to (or as a consequence of): di. Due to (or as a consequence of): dj. Due to (or as a consequence of): dk. Due to (or as a consequence of): dl. Due to (or as a consequence of): dm. Due to (or as a consequence of): dn. Due to (or as a consequence of): do. Due to (or as a consequence of): dp. Due to (or as a consequence of): dq. Due to (or as a consequence of): dr. Due to (or as a consequence of): ds. Due to (or as a consequence of): dt. Due to (or as a consequence of): du. Due to (or as a consequence of): dv. Due to (or as a consequence of): dw. Due to (or as a consequence of): dx. Due to (or as a consequence of): dy. Due to (or as a consequence of): dz. Due to (or as a consequence of): ea. Due to (or as a consequence of): eb. Due to (or as a consequence of): ec. Due to (or as a consequence of): ed. Due to (or as a consequence of): ee. Due to (or as a consequence of): ef. Due to (or as a consequence of): eg. Due to (or as a consequence of): eh. Due to (or as a consequence of): ei. Due to (or as a consequence of): ej. Due to (or as a consequence of): ek. Due															

94 33546

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Ann Sieck Gutekunst				2. DATE OF DEATH MONTH DAY YEAR Oct. 27, 1994		3. TIME OF DEATH 9:21 A M	
4. SOCIAL SECURITY NUMBER 212-52-7127		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 91 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 21, 1903	
8. BIRTHPLACE (State or Foreign Country) Germany				9a. FACILITY NAME (If not institution, give street and number) 2209 Badian Drive		9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring	
9c. COUNTY OF DEATH Montgomery				10a. STATE Maryland		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION Silver Spring				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 2209 Badian Drive	
10f. ZIP CODE 20904				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: White				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12 College (1-4 or 5+) 12			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker				16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Friedrich Sieck				18. MOTHER'S NAME (First, Middle, Maiden Surname) Caroline Büttner			
19a. INFORMANT'S NAME (Type/Print) Madeline Hedeman (Daughter)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as #10			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Suburban Crematory			
20c. LOCATION — City or Town, State Silver Spring, MD				20d. DATE 10-28			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE MO0827				22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P.A. 933 Gist Ave, Silver Spring, MD 20910			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>CEREBRAL INFARCTION</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>ARTERIOSCLEROTIC CEREBRO-VASC D</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>A.S. C.V.D.</u> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST d. <u>PRIOR CEREBRAL INFARCTION</u> PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: <u>PRIOR CEREBRAL INFARCTION</u>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Other (Specify)							
28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
28d. DESCRIBE HOW INJURY OCCURRED							
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)							
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Donald R. Lewis MD							
29c. LICENSE NUMBER DD06406							
29d. DATE SIGNED (Month, Day, Year) 10/27/94							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DONALD R. LEWIS MD OLNEY, MD 20832							
31. DATE FILED (Month, Day, Year) OCT 28 1994							
32. REGISTRAR'S SIGNATURE 							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33547

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) L. Aline Gossett				2. DATE OF DEATH MONTH DAY YEAR October 24, 1994		3. TIME OF DEATH 5:50 A. M	
4. SOCIAL SECURITY NUMBER 578-24-7275		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 91 YRS.	7. DATE OF BIRTH (Month, Day, Year) July 16, 1903		8. BIRTHPLACE (State or Foreign Country) South Carolina	
9a. FACILITY NAME (If not institution, give street and number) Collingswood Nursing Center				9b. CITY, TOWN OR LOCATION OF DEATH Rockville		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Rockville		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 299 Hurley Avenue				10f. ZIP CODE 20850		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Registered Nurse		16b. KIND OF BUSINESS/INDUSTRY Hospital Nursing	
17. FATHER'S NAME (First, Middle, Last) Rudolph King Gossett				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ella Argonia			
19a. INFORMANT'S NAME (Type/Print) Edith S. Callahan				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14810 Springfield Road, Darnestown, MD 20874			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Woodlawn Memorial Park 10/31/94		20c. LOCATION — City or Town, State Greenville, SC			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Will E. Brown, Jr. M00672				22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Uremia DUE TO (OR AS A CONSEQUENCE OF):							
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. Arteriosclerotic Renal Disease DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER John B. Umhau, M.D.				29c. LICENSE NUMBER D11024		29d. DATE SIGNED (Month, Day, Year) October 24, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John B. Umhau, Jr., M.D., 8805 Connecticut Avenue, Chevy Chase, MD 20815							
31. DATE FILED (Month, Day, Year) OCT 27 1994				32. REGISTRAR'S SIGNATURE John Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 may be retained by the funeral director.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33548

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Ranjit Kaur Grewal				2. DATE OF DEATH MONTH DAY YEAR October 11, 1994		3. TIME OF DEATH 7:30 PM	
4. SOCIAL SECURITY NUMBER 214-96-2693		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 81 YRS.		7. DATE OF BIRTH (Month, Day, Year) Mar. 13, 1913	
8. FACILITY NAME (If not institution, give street and number) Shady Grove Adventist Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Rockville		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland				10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Germantown	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 12209 Walnut Creek Court			
10f. ZIP CODE 20879				10g. CITIZEN OF WHAT COUNTRY? India			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Indian	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) Homemaker		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) own Home		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) Nihal Singh Sra				18. MOTHER'S NAME (First, Middle, Maiden Surname) Harnam Kuar Chahal			
19a. INFORMANT'S NAME (Type/Print) Pritam Singh Grewal				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12209 Walnut Creek Court—Germantown, MD 20879			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Northern Va. Crematory 10/13/94		20c. LOCATION — City or Town, State Arlington, Virginia			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Richard D. Fitzgerald</i>				22. NAME AND ADDRESS OF FACILITY Arlington Funeral Home 3901 No. Fairfax Dr—Arlington, VA 20803			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Tuberculosis DUE TO (OR AS A CONSEQUENCE OF): c. Hypertension DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 3 days 2 months Years						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Vascular Disease						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Raman R. Tuli</i>				29c. LICENSE NUMBER D 19609		29d. DATE SIGNED (Month, Day, Year) October 11, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Raman R. Tuli, MD 10810 Damestown Road, #H-2, Gaithersburg, Maryland 20878-2675							
31. DATE FILED (Month, Day, Year) OCT 27 1994				32. REGISTRAR'S SIGNATURE <i>J. Davidson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Amended #1, #11, #206

10/24/94

MRT

Montgomery

94 33549

1 -
FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) GRAVEN, JAMES Anthony Graven				2. DATE OF DEATH MONTH 10 DAY 22 YEAR 94		3. TIME OF DEATH 2:310 M													
4. SOCIAL SECURITY NUMBER 016-18-5971		5. SEX XX M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 30, 1917													
9a. FACILITY NAME (If not institution, give street and number) Washington Adventist Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Takoma Park		9c. COUNTY OF DEATH Montgomery													
10a. STATE Maryland				10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring													
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 14000 Castle Blvd., Apt.#1201															
10f. ZIP CODE 20904				10g. CITIZEN OF WHAT COUNTRY? United States															
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES unknown		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White													
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Insurance Sales		16b. KIND OF BUSINESS/INDUSTRY Private															
17. FATHER'S NAME (First, Middle, Last) James S. Graven				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary V. McNeil															
19a. INFORMANT'S NAME (Type/Print) Ruth E. Clubb				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as #10															
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Port Lincoln Cemetery 10/25/94		20c. LOCATION — City or Town, State 10/25/94 10/25/94 Brentwood, Maryland															
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donald V. Borgwardt</i>				22. NAME AND ADDRESS OF FACILITY Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705															
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Bilateral Cerebral Infarction DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <table border="0"> <tr> <td rowspan="4"> { a. Hypertensive Heart Disease b. Autem Chronic Aspiration pneumonia c. Previous Right Cerebral Infarction d. </td> <td> d. Previous Right Cerebral Infarction </td> <td> Approximate Interval Between Onset and Death 6 mth </td> </tr> <tr> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> </tr> </table>								{ a. Hypertensive Heart Disease b. Autem Chronic Aspiration pneumonia c. Previous Right Cerebral Infarction d.	d. Previous Right Cerebral Infarction	Approximate Interval Between Onset and Death 6 mth									
{ a. Hypertensive Heart Disease b. Autem Chronic Aspiration pneumonia c. Previous Right Cerebral Infarction d.	d. Previous Right Cerebral Infarction	Approximate Interval Between Onset and Death 6 mth																	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <table border="0"> <tr> <td> ① Left laryngeal atelectasis ② Chronic obstructive lung disease ③ Urinary Tract Infection (Acute) </td> <td> 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO </td> <td> 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO </td> </tr> </table>								① Left laryngeal atelectasis ② Chronic obstructive lung disease ③ Urinary Tract Infection (Acute)	24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO									
① Left laryngeal atelectasis ② Chronic obstructive lung disease ③ Urinary Tract Infection (Acute)	24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO																	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO													
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)															
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>S. R. Davidson</i>				29c. LICENSE NUMBER D21200		29d. DATE SIGNED (Month, Day, Year) 10-23-94													
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SHRINIVAS R. UDAPU 7245 Hanover Park Greenbelt MD 20722																			
31. DATE FILED (Month, Day, Year) OCT 24 1994		32. REGISTRAR'S SIGNATURE <i>John Davidson-Gandell</i>																	

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

0554033 UDAPU, SHRINIVAS R.
GRAVEN, JAMES A 3208 2
10-20-94 M 077Y 8-30-17
M/R # 396924

1942

RECEIVED

NOV 19 1942

Wm. H. R. R. R.

RECEIVED

NOV 19 1942



94 33550

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) MARIE A. GALLAGHER				2. DATE OF DEATH MONTH 10 DAY 22 YEAR 94		3. TIME OF DEATH 2130 M	
4. SOCIAL SECURITY NUMBER 202 18 7012		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 90 YRS.		7. DATE OF BIRTH (Month, Day, Year) 9-25-94	
8. BIRTHPLACE (State or Foreign Country) Indiana				9. FACILITY NAME (If not institution, give street and number) Anne Arundel Medical Center			
10. STATE Maryland				10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Annapolis	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				9c. COUNTY OF DEATH Anne Arundel			
10e. STREET AND NUMBER 130 Hearne Rd.				10f. ZIP CODE 21401		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES No		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: No		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Manager		16b. KIND OF BUSINESS/INDUSTRY Catalogue Sales			
17. FATHER'S NAME (First, Middle, Last) Patrick McIntyre				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Murphy			
19a. INFORMANT'S NAME (Type/Print) Gayle Marie Hughes				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1880 Harcourt Ave. Crofton Maryland 21114			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. LOCATION — City or Town, State Alexandria Va.		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert E. Evans Pres				22. NAME AND ADDRESS OF FACILITY Beall-Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Md. 20715			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Intracerebral Hemorrhage DUE TO (OR AS A CONSEQUENCE OF): b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST						Approximate interval between Onset and Death 24 hrs	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]		29c. LICENSE NUMBER 036488		29d. DATE SIGNED (Month, Day, Year) 10/23/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) OCT 26 1994		32. REGISTRAR'S SIGNATURE [Signature]					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED

RECEIVED

RECEIVED

RECEIVED

12

RECEIVED

94 33551

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Flora Gray</i>				2. DATE OF DEATH MONTH DAY YEAR 10 16 94		3. TIME OF DEATH 01:51 M	
4. SOCIAL SECURITY NUMBER 577-60-2659		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 88 YRS.		7. DATE OF BIRTH (Month, Day, Year) 7 14 06	
8. FACILITY NAME (If not institution, give street and number) Adventist Washington Hospital				9. CITY, TOWN OR LOCATION OF DEATH Takoma Park		10. COUNTY OF DEATH Montgomery	
11a. STATE D. C.		11b. COUNTY N/A		11c. CITY, TOWN OR LOCATION Washington		11d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
12a. STREET AND NUMBER 1227 Randolph Street, N. W.				12b. ZIP CODE 20011		12c. CITIZEN OF WHAT COUNTRY? USA	
13. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		14. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		15. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		16. RACE — American Indian, Black, White, etc. Specify: Black	
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10th		18. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Elevator Operator		19. KING OF BUSINESS/INDUSTRY GSA			
20. FATHER'S NAME (First, Middle, Last) Emmett Trent				21. MOTHER'S NAME (First, Middle, Maiden Surname) Ada Trent			
22. INFORMANT'S NAME (Type/Print) Frances Johnson				23. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 934 Quincy Street NW Washington DC 20011			
24a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		24b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Bland/Reed Funeral Home 10-19 Farmville Va.		24c. LOCATION — City or Town, State		24d. DATE	
25. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>J. P. Marshall</i>				26. NAME AND ADDRESS OF FACILITY Marshall's Funeral Home Inc 4217 9th Street, NW Washington, D. C. 20011			
27. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>thyroid cancer</i> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): <i>atherosclerotic coronary artery disease</i> c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate interval between Onset and Death <i>months</i> <i>years</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
28. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>				29a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		29b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
30. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		31. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
32. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		33a. DATE OF INJURY (Month, Day, Year)		33b. TIME OF INJURY M		33c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
34. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)				35. DESCRIBE HOW INJURY OCCURRED			
36. LOCATION (Street and Number or Rural Route Number, City or Town, State)				37. DATE OF INJURY			
38. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
39. SIGNATURE AND TITLE OF CERTIFIER <i>Maria A. Dobson</i>				40. LICENSE NUMBER D29923		41. DATE SIGNED (Month/Day/Year) 10/17/94	
42. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 7243 B Andrews Pkwy Greenbelt, MD 20770							
43. DATE FILED (Month, Day, Year) OCT 27 1994				44. REGISTRAR'S SIGNATURE <i>Gina Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician to the FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33552

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Thomas D Gellner				2. DATE OF DEATH MONTH 10 / DAY 31 / YEAR 94		3. TIME OF DEATH 3:46PM	
4. SOCIAL SECURITY NUMBER 219 56 7526		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 45 YRS.		7. DATE OF BIRTH (Month, Day, Year) 11/9/48	
9a. FACILITY NAME (If not institution, give street and number) 224 Harrison St Apt 1				9b. CITY, TOWN OR LOCATION OF DEATH Cumberland		9c. COUNTY OF DEATH Allegany	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Allegany		10c. CITY, TOWN OR LOCATION Cumberland		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER Apt 1 224 Harrison St				10f. ZIP CODE 21502		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES VIET NAM		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) MACHINIST		16b. KIND OF BUSINESS/INDUSTRY TRUCKING			
17. FATHER'S NAME (First, Middle, Last) NORMAN J. GELLNER				18. MOTHER'S NAME (First, Middle, Maiden Surname) CATHERINE L. GOLDSWORTHY			
19a. INFORMANT'S NAME (Type/Print) CATHERINE L. VANCE				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROUTE 2, BOX 136 FLINTSTONE, MD 21530			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) REST LAWN MEM. GARDENS 3rd		20c. LOCATION — City or Town, State LAVALE, MD		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE John J. Hafer, Jr.				22. NAME AND ADDRESS OF FACILITY HAFER CHAPEL OF THE HILLS 1302 NAT'L HWY., LAVALE, MD 21502			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Coronary artery heart disease DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate interval between Onset and Death 6 years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Nicotine and alcohol abuse							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Dpty Med Ex				29c. LICENSE NUMBER D 09157		29d. DATE SIGNED (Month, Day, Year) 10/31/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Paul Snow, M.D. 124 w 3rd st Cumb MD 21502							
31. DATE FILED (Month, Day, Year) NOV 03 1994				32. REGISTRAR'S SIGNATURE Julia M. [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33553

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Arthur Hoffman, Jr.				2. DATE OF DEATH MONTH DAY YEAR Nov. 2, 1994		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 213-16-0200		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec. 25, 1920	
9a. FACILITY NAME (If not institution, give street and number) 1001 St. Clair Street				9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown		9c. COUNTY OF DEATH Washington	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Hagerstown		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1001 St. Clair Street				10f. ZIP CODE 21742		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) staff manager		16b. KIND OF BUSINESS/INDUSTRY Insurance			
17. FATHER'S NAME (First, Middle, Last) Arthur Hoffman Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Semler			
19a. INFORMANT'S NAME (Type/Print) H. Sharlene Griffith				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1001 St. Clair St., Hagerstown, Maryland 21742			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Rose Hill Cemetery 11-5-94		20c. LOCATION — City or Town, State Hagerstown, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Scott Munnick</i>				22. NAME AND ADDRESS OF FACILITY MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Cardiac arrest</i> DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. <i>Intermittent Heart Disease</i> DUE TO (OR AS A CONSEQUENCE OF):					
		c. <i>Coronary atherosclerosis</i> DUE TO (OR AS A CONSEQUENCE OF):					
		d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>L. L. Packer, Jr. M.D.</i>				29c. LICENSE NUMBER D09930		29d. DATE SIGNED (Month, Day, Year) 11/4/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) L. L. PACKER, JR. M.D. 145 W. Wash. St. Hagerstown Md. 21740							
31. DATE FILED (Month, Day, Year) NOV 04 1994		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33554

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ALICE Mary HAYES				2. DATE OF DEATH MONTH DAY YEAR OCT. 22 94		3. TIME OF DEATH 08:52 A M	
4. SOCIAL SECURITY NUMBER 579-01-9096		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 75 YRS.		7. DATE OF BIRTH (Month, Day, Year) 1919 September 21, Massachusetts	
9a. FACILITY NAME (If not institution, give street and number) Suburban Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Bethesda		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Wheaton		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 2808 Dawson Avenue				10f. ZIP CODE 20902		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 1		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary		16b. KIND OF BUSINESS/INDUSTRY Education			
17. FATHER'S NAME (First, Middle, Last) Francis P. McGrady				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Agnes Hickey			
19a. INFORMANT'S NAME (Type/Print) Frank Rowe Hayes				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2808 Dawson Avenue Wheaton, Maryland 20902			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parklawn Cemetery 10/25/94		20c. LOCATION — City or Town, State Rockville, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Timothy J. Campbell				22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → UPPER GASTROINTESTINAL Hemorrhage DUE TO (OR AS A CONSEQUENCE OF): a. CIRRHOSIS DUE TO (OR AS A CONSEQUENCE OF): c. FRACTURED HIP (R) DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death 10 DAYS INDEF 18 DAYS
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 10 4 94		28b. TIME OF INJURY 1800 M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) HOME		28e. DESCRIBE HOW INJURY OCCURRED FELL			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) # 10							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Francis C. Mayle				29c. LICENSE NUMBER 007099		29d. DATE SIGNED (Month, Day, Year) 10/22/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FRANCIS C MAYLE 10215 FERNWOOD RD BETHESDA MD 20817 1106							
31. DATE FILED (Month, Day, Year) OCT 26 1994				32. REGISTRAR'S SIGNATURE John Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33555

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Phileman Henry HUG				2. DATE OF DEATH MONTH DAY YEAR October 21, 1994		3. TIME OF DEATH 4:35P																						
4. SOCIAL SECURITY NUMBER 162-16-7821		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 75 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 14, 1919																						
9a. FACILITY NAME (If not institution, give street and number) Doctors Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Lanham		9c. COUNTY OF DEATH P.G.																						
RESIDENCE OF DECEDENT																												
10a. STATE MD.		10b. COUNTY P.G.		10c. CITY, TOWN OR LOCATION Hyattsville		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO																						
10e. STREET AND NUMBER 8323 Quentin St.				10f. ZIP CODE 20784		10g. CITIZEN OF WHAT COUNTRY? U.S.A.																						
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W.W.II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White																						
15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY																								
Elementary/Secondary (0-12) 12		College (1-4 or 5+) -----		A.C. Mechanic		Greyhound Bus Lines																						
17. FATHER'S NAME (First, Middle, Last) Henry Hug				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ida Littauer																								
19a. INFORMANT'S NAME (Type/Print) Wayne H. Hug				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5820 Royal Ridge RD. Springfield, Va. 22152																								
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Chambers Crematory		DATE 10/25		20c. LOCATION — City or Town, State Riverdale, MD.																						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Thomas S. Chamber 670				22. NAME AND ADDRESS OF FACILITY W.W. Chambers Co. Inc. 5801 Cleveland Ave. Riverdale, MD. 20737																								
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																												
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Asystole / Hypertension																												
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST																												
<table border="0"> <tr> <td rowspan="4">{</td> <td>a.</td> <td>DUE TO (OR AS A CONSEQUENCE OF):</td> <td>bleeding / probable infection</td> <td>Approximate Interval Between Onset and Death</td> <td>1 day</td> </tr> <tr> <td>b.</td> <td>DUE TO (OR AS A CONSEQUENCE OF):</td> <td>Cancer of colon with resection</td> <td></td> <td>1 wk</td> </tr> <tr> <td>c.</td> <td>DUE TO (OR AS A CONSEQUENCE OF):</td> <td>Status post whipple procedure</td> <td></td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> <td></td> <td></td> </tr> </table>								{	a.	DUE TO (OR AS A CONSEQUENCE OF):	bleeding / probable infection	Approximate Interval Between Onset and Death	1 day	b.	DUE TO (OR AS A CONSEQUENCE OF):	Cancer of colon with resection		1 wk	c.	DUE TO (OR AS A CONSEQUENCE OF):	Status post whipple procedure			d.				
{	a.	DUE TO (OR AS A CONSEQUENCE OF):	bleeding / probable infection	Approximate Interval Between Onset and Death	1 day																							
	b.	DUE TO (OR AS A CONSEQUENCE OF):	Cancer of colon with resection		1 wk																							
	c.	DUE TO (OR AS A CONSEQUENCE OF):	Status post whipple procedure																									
	d.																											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. diabetes																												
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																												
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one)																								
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA				OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																								
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																						
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED																								
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED																								
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																												
29b. SIGNATURE AND TITLE OF CERTIFIER Rashid Baghai Naeni				29c. LICENSE NUMBER D 39372		29d. DATE SIGNED (Month, Day, Year) 10-24-94																						
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Rashid Baghai-Naeni 344 University Blvd. West Suite 326 Silver Spring, MD 20901																												
31. DATE FILED (Month, Day, Year) OCT 25 1994				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall																								

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit form to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33556

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Margaret Smith Henderson				2. DATE OF DEATH MONTH DAY YEAR October 19 1994		3. TIME OF DEATH H M 5:15 A	
4. SOCIAL SECURITY NUMBER 579-09-7919		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) 87 YRS.		7. DATE OF BIRTH (Month, Day, Year) MARCH 12, 1907	
9a. FACILITY NAME (If not institution, give street and number) Aspen Wood Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland				10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 14400 Homecrest Road #33			
10f. ZIP CODE 20906				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Secretary				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary		16b. KIND OF BUSINESS/INDUSTRY Federal Government	
17. FATHER'S NAME (First, Middle, Last) Sidney Sample Smith				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Annie Elizabeth Biddell			
19a. INFORMANT'S NAME (Type/Print) Margaret Jean Hobday				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt 1, Box 200C Castalia, North Carolina 27816			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parklawn Cemetery 10/22/94		20c. LOCATION — City or Town, State Rockville, Maryland		21. SIGNATURE OF FUNERAL SERVICE LICENSEE Christopher Marlburn	
22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): b. Critical Aortic Stenosis DUE TO (OR AS A CONSEQUENCE OF): c. Coronary Arteriosclerosis DUE TO (OR AS A CONSEQUENCE OF): d. Type II Diabetes Mellitus Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Gastrointestinal bleeding						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER P. A. Henderson MD Attending Phys.				29c. LICENSE NUMBER D35045		29d. DATE SIGNED (Month, Day, Year) 10-19-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) Philip Henderson MD 13975 Conn. Ave #308 SS, MD 20906							
31. DATE FILED (Month, Day, Year) OCT 24 1994				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33557

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Sara Irene Hubbert				2. DATE OF DEATH MONTH DAY YEAR October 21, 1994		3. TIME OF DEATH 1900 M	
4. SOCIAL SECURITY NUMBER 219-10-2150		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 68 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 7, 1926	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) 29 Molitor Road		9b. CITY, TOWN OR LOCATION OF DEATH Elkton	
9c. COUNTY OF DEATH Cecil				10a. STATE Maryland		10b. COUNTY Cecil	
10c. CITY, TOWN OR LOCATION Elkton				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 29 Molitor Road	
10f. ZIP CODE 21921				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: White				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2			
15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Cafeteria Manager				15b. KIND OF BUSINESS/INDUSTRY School System			
17. FATHER'S NAME (First, Middle, Last) William Richard Warpole, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Amy Albers			
19a. INFORMANT'S NAME (Type/Print) Albert L. Hubbert, Sr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 973 - Elkton, MD 21922			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cherry Hill Methodist Cem. 10-25 1994			
20c. LOCATION — City or Town, State Cherry Hill, MD				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James S. Hicks</i>			
22. NAME AND ADDRESS OF FACILITY Hicks Home for Funerals, P.A. 103 West Stockton Street Elkton, MD 21921-5521				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Adenocarcinoma of unknown primary site</i> DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate interval between Onset and Death 11 Months			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURRED 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>James S. Hicks</i>			
29c. LICENSE NUMBER 23099				29d. DATE SIGNED (Month, Day, Year) 10/24/94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 138 Calhoun Street, Elkton, MD 21921							
31. DATE FILED (Month, Day, Year) 06/28/94				32. REGISTRAR'S SIGNATURE <i>James S. Hicks</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33558

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) WESLEY SAMUEL HARRIS			2. DATE OF DEATH MONTH DAY YEAR OCT 20 1994		3. TIME OF DEATH 9:25 A
4. SOCIAL SECURITY NUMBER 231-48-2268	5. SEX 1 M 2 F	6. AGE (In yrs. last birthday) 55 YRS.	7. DATE OF BIRTH (Month, Day, Year) AUGUST 27, 1939	8. BIRTHPLACE (State or Foreign Country) WASHINGTON D.C.	
9a. FACILITY NAME (If not institution, give street and number) PRINCE GEORGES HOSPITAL CENTER			9b. CITY, TOWN OR LOCATION OF DEATH CHEVERLY		9c. COUNTY OF DEATH PRINCE GEORGES
RESIDENCE OF DECEDENT					
10a. STATE MARYLAND	10b. COUNTY PRINCE GEORGES		10c. CITY, TOWN OR LOCATION LANDOVER		10d. INSIDE CITY LIMITS? 1 X YES 2 NO
10e. STREET AND NUMBER 2240 BRIGHTSEAT ROAD #201			10f. ZIP CODE 20785	10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: BLACK		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) College			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) PRODUCE CLERK		16b. KIND OF BUSINESS/INDUSTRY PRIVATE			
17. FATHER'S NAME (First, Middle, Last) LESLIE SAMUEL HARRIS			18. MOTHER'S NAME (First, Middle, Maiden Surname) NIDA JOHNSON		
19a. INFORMANT'S NAME (Type/Print) NIDA J. ROBINSON			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2240 BRIGHTSEAT ROAD #201 LANDOVER, MARYLAND 20785		
20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) FT. LINCOLN CEMETERY		20c. LOCATION — City or Town, State 10-25 BLADENSBURG, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Kimberly C. Bruce Tonic			22. NAME AND ADDRESS OF FACILITY J.B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MD 20785		
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Hypertensive arteriosclerotic cardiac muscular disease DOE TO (OR AS A CONSEQUENCE OF): Sequitally flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DOE TO (OR AS A CONSEQUENCE OF): DOE TO (OR AS A CONSEQUENCE OF): DOE TO (OR AS A CONSEQUENCE OF):					Approximate interval between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Curvature of the tongue					24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)			
27. MANNER OF DEATH 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 YES 2 NO	28d. DESCRIBE HOW INJURY OCCURRED
29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Alfonso Valle, MD			
29c. LICENSE NUMBER D12879		29d. DATE SIGNED (Month, Day, Year) Oct 31, 1994			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ALFONSO VALLE, M.D. 10701 TRAFON DR, LARGO, MD 20772					
31. DATE FILED (Month, Day, Year) OCT 24 1994		32. REGISTRAR'S SIGNATURE John Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. To be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

AMENDED #17, 10/26/94, CYW, P.G. COUNTY

94 33559

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Florence E. Hardman				2. DATE OF DEATH MONTH DAY YEAR October 22, 1994		3. TIME OF DEATH 2:20 P. M.	
4. SOCIAL SECURITY NUMBER 579-10-0959		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan. 25, 1909	
8. BIRTHPLACE (State or Foreign Country) Washington, D.C.				9a. FACILITY NAME (If not institution, give street and number) Greenbelt Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH Greenbelt	
9c. COUNTY OF DEATH Prince George's				10a. STATE Maryland		10b. COUNTY Prince George's	
10c. CITY, TOWN OR LOCATION Bowie				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 12432 Melling Lane	
10f. ZIP CODE 20715				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (13-16) 5+				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Retired Fed. Gov't.		16b. KIND OF BUSINESS/INDUSTRY Bookkeeper	
17. FATHER'S NAME (First, Middle, Last) James C. Higgs				18. MOTHER'S NAME (First, Middle, Maiden Surname) Julia R. Taylor			
19a. INFORMANT'S NAME (Type/Print) Donald A. Hardman				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as item 10			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 10/24/94		20c. LOCATION — City or Town, State Alexandria, Va.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George P. Kalas</i>				22. NAME AND ADDRESS OF FACILITY George P. Kalas Funeral Home 6160 Oxon Hill Rd., Oxon Hill, Md. 20745			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. <i>Natural</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Quadruplex</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>Severe Parkinson's</i> DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Other		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Robert J. Gereige</i>				29c. LICENSE NUMBER D20302		29d. DATE SIGNED (Month, Day, Year) 10/24/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert J. Gereige, M.D. 4410 - 74th Ave. Landover Hills, Md. 20784							
31. DATE FILED (Month, Day, Year) OCT 25 1994				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.
TO BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPT. OF HEALTH AND MENTAL HYGIENE PRIOR TO BURIAL, CREMATION, OR REMOVAL.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33560

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ANN C. HALL				2. DATE OF DEATH MONTH DAY YEAR 10 - 16 - 94				3. TIME OF DEATH 6:55 PM M							
4. SOCIAL SECURITY NUMBER 577-48-7186		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 63 YRS.	7. DATE OF BIRTH (Month, Day, Year) 10-26-31		8. BIRTHPLACE (State or Foreign Country) Brooklyn, NY									
9a. FACILITY NAME (If not institution, give street and number) PRINCE GEORGES COUNTY HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH Cheverly			9c. COUNTY OF DEATH Prince Georges								
10a. STATE Maryland				10b. COUNTY Calvert		10c. CITY, TOWN OR LOCATION Lothian			10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO						
10e. STREET AND NUMBER 256 Rips Drive				10f. ZIP CODE 20711		10g. CITIZEN OF WHAT COUNTRY? USA									
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE - American Indian, Black, White, etc. Specify: White								
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Admin. Assistant			16b. KIND OF BUSINESS/INDUSTRY Bolling A.F. Base								
17. FATHER'S NAME (First, Middle, Last) Francis Masi				18. MOTHER'S NAME (First, Middle, Maiden Surname) Kathleen Martin											
19a. INFORMANT'S NAME (Type/Print) Ronald Masi				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 122 Lamport Rd., Reistertown, MD 21136											
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place) Cedar Hill Cemetery 10/21		20c. LOCATION - City or Town, State Suitland, MD									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Julius P. Marshall</i>				22. NAME AND ADDRESS OF FACILITY Marshall's Funeral Home, Inc. 4308 Suitland Rd. Suitland, MD 20746											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Gastro Intestinal Hemorrhage DUE TO (OR AS A CONSEQUENCE OF): b. Peptic Ulcer Disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate interval between Onset and Death 8 hours							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pancreatic Carcinoma Resistant Phlebitis DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29b. SIGNATURE AND TITLE OF CERTIFIER <i>Michael York MD</i>		29c. LICENSE NUMBER D 28494		29d. DATE SIGNED (Month, Day, Year) 10/17/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Michael York MD 5506 Green Landing Rd. Upper Marlboro. MD 20772															
31. DATE FILED (Month, Day, Year) OCT 25 1994				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>											

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33561

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ELIZABETH STRADLEY HOWELL				2. DATE OF DEATH MONTH DAY YEAR OCTOBER 27, 1994		3. TIME OF DEATH 2:45 A M	
4. SOCIAL SECURITY NUMBER 578-52-1148		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 87 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 23, 1907	
9a. FACILITY NAME (If not institution, give street and number) Prince George's Hospital Center				9b. CITY, TOWN OR LOCATION OF DEATH Cheverly		9c. COUNTY OF DEATH Prince George's	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Mitchellville		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 10450 Lottsford Road				10f. ZIP CODE 20721		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 1				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home	
17. FATHER'S NAME (First, Middle, Last) Samuel Gover Kettlewell Stradley				18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Hoxsey Davis			
19a. INFORMANT'S NAME (Type/Print) Margaret Cray				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3205 Mason Avenue, Las Vegas, Nevada 89102			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 10/28/94		20c. LOCATION — City or Town, State Alexandria, Virginia			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Charles F. Bell				22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death 1 week
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Delirium, chronic obstructive pulmonary disease							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature] Attending Physician				29c. LICENSE NUMBER D25071		29d. DATE SIGNED (Month, Day, Year) 10/27/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Don H. Yablonsky, no 7425 Forbes Blvd, Jeolbrook, no 20706							
31. DATE FILED (Month, Day, Year) OCT 28 1994				32. REGISTRAR'S SIGNATURE [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

10

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

TO BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPT. OF HEALTH AND MENTAL HYGIENE PRIOR TO BURIAL, CREMATION, OR REMOVAL.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33562

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) EVELYN PAULINE HIETT				2. DATE OF DEATH MONTH 10 DAY 31 YEAR 94		3. TIME OF DEATH 4:45 P M	
4. SOCIAL SECURITY NUMBER 236 36 1607		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 18, 1920	
9a. FACILITY NAME (If not institution, give street and number) SACRED HEART HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND		9c. COUNTY OF DEATH ALLEGANY	
10a. STATE WV				10b. COUNTY Mineral		10c. CITY, TOWN OR LOCATION Ridgeley	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER Route 2 Box 239R		10f. ZIP CODE 26753	
10g. CITIZEN OF WHAT COUNTRY? USA				11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: white			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 12 Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home	
17. FATHER'S NAME (First, Middle, Last) Bruce F. Blauch				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ethel M. (McKenzie)			
19a. INFORMANT'S NAME (Type/Print) Bonnie Blackiston				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Route 2 Box 239R; Ridgeley, WV 26753			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Pinto Mennonite Cemetery 11/3		20c. LOCATION — City or Town, State Pinto, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James F. Scarpelli</i>				22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Massive Cerebral Hemorrhage DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death 100 Hrs
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Sulfide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER D22181		29d. DATE SIGNED (Month, Day, Year) 11-1-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. GARY WAGONER, M.D. 925 BISHOP WALSH ROAD, CUMBERLAND, MD 21502							
31. DATE FILED (Month, Day, Year) NOV 02 1994				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician to the FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit receipt. Page 7, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



SEP 11 1961

94 33563

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CHARLES R. HOWDYSHELL				2. DATE OF DEATH MONTH DAY YEAR Nov. 1, 1994		3. TIME OF DEATH 12:30 A M	
4. SOCIAL SECURITY NUMBER 214-07-0199		5. SEX 1 M 2 F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 21, 1911	
9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Cumberland		9c. COUNTY OF DEATH Allegany	
10a. STATE MD				10b. COUNTY Allegany		10c. CITY, TOWN OR LOCATION Cumberland	
10d. INSIDE CITY LIMITS? 1 X YES 2 NO				10e. STREET AND NUMBER 123 Oak Street			
10f. ZIP CODE 21502				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 X Never Married 2 Married 3 Widowed 4 Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 X NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 12 Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Retired maintenance		16b. KIND OF BUSINESS/INDUSTRY Hospital	
17. FATHER'S NAME (First, Middle, Last) Charles E. Howdysshell				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Mae (Chamberlin)			
19a. INFORMANT'S NAME (Type/Print) Barbara J. McFarland				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 203 Potomac Street; Cumberland, MD 21502			
20a. METHOD OF DISPOSITION 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hillcrest Burial Park 11/3		20c. LOCATION — City or Town, State Cumberland, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James F. Scarpelli</i>				22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Renal failure DUE TO (OR AS A CONSEQUENCE OF): a. Renal failure b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 X NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 X NO		28. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)					
27. MANNER OF DEATH 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 8 Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 YES 2 NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>H. C. Merrick</i>				29c. LICENSE NUMBER D 28910		29d. DATE SIGNED (Month, Day, Year) 11/1/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. H.C. Merrick, Memorial Hospital Medical Bldg., Cumberland, MD 21502							
31. DATE FILED (Month, Day, Year) NOV 02 1994				32. REGISTRAR'S SIGNATURE <i>John Anderson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Amended # 206, 11/2/94, N.L.S., Allegany Co.

94 33564

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HAROLD LEE HAINES				2. DATE OF DEATH MONTH October DAY 28 , YEAR 1994				3. TIME OF DEATH 1:30 A M			
4. SOCIAL SECURITY NUMBER 236-54-8808		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 57 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 20, 1937		8. BIRTHPLACE (State or Foreign Country) West Va			
9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Cumberland				9c. COUNTY OF DEATH Allegany			
RESIDENCE OF DECEDENT											
10a. STATE MARYLAND		10b. COUNTY ALLEGANY		10c. CITY, TOWN OR LOCATION CUMBERLAND				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER 329 BEDFORD STREET				10f. ZIP CODE 21502		10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1956-1962		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) MAINTENANCE WORKER		16b. KIND OF BUSINESS/INDUSTRY CITY OF CUMBERLAND							
17. FATHER'S NAME (First, Middle, Last) WILLIAM E. HAINES				18. MOTHER'S NAME (First, Middle, Maiden Surname) IRENE FRANCES SELF							
19a. INFORMANT'S NAME (Type/Print) ELIZABETH HAINES				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 329 BEDFORD STREET - CUMBERLAND, MD 21502							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) FT. ASHBY CEMETERY 3/31/94		20c. LOCATION — City or Town, State FT. ASHBY, WV							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Wendy D. Upchurch</i>				22. NAME AND ADDRESS OF FACILITY GEORGE-UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Myocardial infarction</i> Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): <i>Coronary artery disease</i> b. DUE TO (OR AS A CONSEQUENCE OF): <i>Arteriosclerosis</i> c. DUE TO (OR AS A CONSEQUENCE OF): <i>Diabetes mellitus</i> d. DUE TO (OR AS A CONSEQUENCE OF): Approximate interval Between Onset and Death											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Vik Poonai</i>						29c. LICENSE NUMBER D 36766		29d. DATE SIGNED (Month, Day, Year) 11/2/94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Vik Poonai 955 Frederick St. Cumberland, MD 21502											
31. DATE FILED (Month, Day, Year) NOV 01 1994				32. REGISTRAR'S SIGNATURE <i>John S. Randall</i>							

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

94 33565

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CHARLES E. HARRIS				2. DATE OF DEATH MONTH OCT. DAY 28 YEAR 1994		3. TIME OF DEATH M M	
4. SOCIAL SECURITY NUMBER 212-34-2452		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 55 YRS.		7. DATE OF BIRTH (Month, Day, Year) 11 21 1938	
9a. FACILITY NAME (If not institution, give street and number) ANNE ARUNDEL MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH ANNAPOLIS		8. BIRTHPLACE (State or Foreign Country) MARYLAND	
9c. COUNTY OF DEATH ANNE ARUNDEL							
10a. STATE MARYLAND		10b. COUNTY ANNE ARUNDEL		10c. CITY, TOWN OR LOCATION ANNAPOLIS		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1195 MADISON STREET				10f. ZIP CODE 21403		10g. CITIZEN OF WHAT COUNTRY? U.S.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4 or 5+) MEAT CUTTER		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) MEAT CUTTER		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) CHARLES E. HARRIS, SR.				18. MOTHER'S NAME (First, Middle, Maiden Surname) LOUISE CROMWELL			
19a. INFORMANT'S NAME (Type/Print) TERRI HARRIS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 705 D NEWTOWN DR. ANNAPOLIS, MD. 21401			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ASBURY BROADNECK CHURCH CEME. 11/2/94 ST. MARGARETS, MD.		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Harry B. Reese				22. NAME AND ADDRESS OF FACILITY REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Adult Respiratory Distress Syndrome DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death 1 wk	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alcoholic Cirrhosis						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		26a. DATE OF INJURY (Month, Day, Year)		26b. TIME OF INJURY M		26c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		26d. DESCRIBE HOW INJURY OCCURED					
26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Wayne Blarburn, MD				29c. LICENSE NUMBER D38563		29d. DATE SIGNED (Month, Day, Year) 11/2/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Wayne Blarburn 131 Owensville Rd West River, MD							
31. DATE FILED (Month, Day, Year) NOV 03 1994				32. REGISTRAR'S SIGNATURE John D. ...			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33566

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) William Henry Johnson				2. DATE OF DEATH MONTH DAY YEAR 10/29/1994		3. TIME OF DEATH 4:30 A.M.	
4. SOCIAL SECURITY NUMBER 214-24-2870		5. SEX <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female		6. AGE (In yrs. last birthday) 67 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 9, 1927	
8. BIRTHPLACE (State or Foreign Country) Pa.				9a. FACILITY NAME (If not institution, give street and number) 10183 Winston Dr.		9b. CITY, TOWN OR LOCATION OF DEATH Frederick	
9c. COUNTY OF DEATH Frederick				10a. STATE Md		10b. COUNTY Frederick	
10c. CITY, TOWN OR LOCATION Frederick				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 10183 Winston Dr.	
10f. ZIP CODE 21701				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES no no				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 10				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Merchant Marine		16b. KIND OF BUSINESS/INDUSTRY Shipping	
17. FATHER'S NAME (First, Middle, Last) Alonza Wilford Johnson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sossie Etta Rogers			
19a. INFORMANT'S NAME (Type/Print) Lena M. Johnson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10183 Winston Dr. Frederick Md 21701			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Loudon Park Cemetery		20c. LOCATION — City or Town, State Baltimore, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY D. D. HARTZLER & SONS Libertytown, Md.			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Hepatic coma</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Cirrhosis</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>Chronic Active Hepatitis B</u> DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Diabetes mel</u>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>James F. Hartzler, MD</i>				29c. LICENSE NUMBER D-14637		29d. DATE SIGNED (Month, Day, Year) 10/31/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 915 Jolt House Ave #201 Frederick MD 21701							
31. DATE FILED (Month, Day, Year) 10/31/94				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



James M. Haggitt
Chicago
Chicago Electric Light & Power Co.

June 10, 1901

Dear Sir:
I have the honor to acknowledge the receipt of your letter of the 6th inst. in relation to the above matter.

94 33567

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Paul Jones Johnson				2. DATE OF DEATH MONTH DAY YEAR October 24, 1994		3. TIME OF DEATH 9:15 PM	
4. SOCIAL SECURITY NUMBER 217-05-4163		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) October 29, 1919	
8. BIRTHPLACE (State or Foreign Country) Maryland				9. COUNTY OF DEATH Frederick			
9a. FACILITY NAME (If not institution, give street and number) 1201 Maple Terrace Lane Apt. 302C				9b. CITY, TOWN OR LOCATION OF DEATH Brunswick		9c. COUNTY OF DEATH Frederick	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Brunswick		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 1201 Maple Terrace Lane Apt. 302C				10f. ZIP CODE 21716		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) 9		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Crane Operator		16b. KIND OF BUSINESS/INDUSTRY D.C. Government			
17. FATHER'S NAME (First, Middle, Last) George Johnson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Altie Walter			
19a. INFORMANT'S NAME (Type/Print) Shirley M. Johnson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1201 Maple Terrace Lane #302C Brunswick, Maryland 21716			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Cemetery 10/27/94 Brentwood, Maryland		20c. LOCATION — City or Town, State		20d. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jones & Daugherty</i>				22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>aspiration</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Parkinson's disease</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate interval Between Onset and Death 4-5 d years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>ASCVD</i>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Kathleen W Stern MD</i>				29c. LICENSE NUMBER D32073		29d. DATE SIGNED (Month, Day, Year) 10/24/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Kathleen Stern MD, 610 Ninth Ave, Brunswick, Md. 21716							
31. DATE FILED (Month, Day, Year) OCT 27 1994				32. REGISTRAR'S SIGNATURE <i>Jane Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33568

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HECTOR ARTURO JARVIS				2. DATE OF DEATH MONTH DAY YEAR OCT. 21, 1994		3. TIME OF DEATH 12:20 P. M.		
4. SOCIAL SECURITY NUMBER		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) YRS. MONTHS DAYS 1 1		7. DATE OF BIRTH (Month, Day, Year) OCT. 21, 1994		8. BIRTHPLACE (State or Foreign Country) MARYLAND	
9a. FACILITY NAME (If not institution, give street and number) HOLY CROSS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH SILVER SPRING		9c. COUNTY OF DEATH MONTGOMERY		
10a. STATE MARYLAND		10b. COUNTY MONTGOMERY		10c. CITY, TOWN OR LOCATION WHEATON		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STREET AND NUMBER 11516 GEORGIA AVE.				10f. ZIP CODE 20902		10g. CITIZEN OF WHAT COUNTRY? U.S.A.		
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: PANAMANIAN		14. RACE — American Indian, Black, White, etc. Specify: BLACK		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY				
17. FATHER'S NAME (First, Middle, Last) ARTURO MINOR				18. MOTHER'S NAME (First, Middle, Maiden Surname) BELINDA JARVIS				
19a. INFORMANT'S NAME (Type/Print) BELINDA JAVIS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11516 GEORGIA AVE WHEATON MD. 20902				
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT. COMFORT CREMATORY		DATE 10/28		20c. LOCATION — City or Town, State ALEXANDRIA, VA.		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Alan M. Peters</i>				22. NAME AND ADDRESS OF FACILITY JOSEPH GAWLER'S, INC 5130 WI. AVE. N.W. WASHINGTON, DC 20016				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Extreme immaturity DUE TO (OR AS A CONSEQUENCE OF):						
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. DUE TO (OR AS A CONSEQUENCE OF):						
		c. DUE TO (OR AS A CONSEQUENCE OF):						
		d. DUE TO (OR AS A CONSEQUENCE OF):						
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>								
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) N/A		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		
28d. DESCRIBE HOW INJURY OCCURRED				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Katherine C. White MD Staff Neonatologist</i>						
		29c. LICENSE NUMBER D28737		29d. DATE SIGNED (Month, Day, Year) 10/21/94				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Katherine C. White M.D. Holy Cross Hospital 1500 Forest Glen Rd. Sil. Sp. Md								
31. DATE FILED (Month, Day, Year) OCT 28 1994		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>						

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33569

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Anne Marie Jones</i>				2. DATE OF DEATH MONTH <i>October</i> DAY <i>17</i> YEAR <i>1994</i>				3. TIME OF DEATH <i>6:30 A.M.</i>	
4. SOCIAL SECURITY NUMBER <i>499-36-1873</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>70</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>July 30, 1994</i>		8. BIRTHPLACE (State or Foreign Country) <i>Memphis, Tenn.</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>6609 23rd Pl.</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Hyattsville,</i>				9c. COUNTY OF DEATH <i>Prince Georges</i>	
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Prince Georges</i>		10c. CITY, TOWN OR LOCATION <i>Hyattsville</i>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>6609 23rd Pl.</i>				10f. ZIP CODE <i>20782</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>Elementary Secondary (0-12) 12</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Registered Nurse</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Private Industry</i>					
17. FATHER'S NAME (First, Middle, Last) <i>George Carter</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Elmira Milsaps</i>					
19a. INFORMANT'S NAME (Type/Print) <i>Earlene McClain</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>6609 23rd Pl., Hyattsville, Md., 20782</i>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Glenwood Cemetery</i>		DATE <i>Oct. 22, 1994</i>		20c. LOCATION — City or Town, State <i>Washington, D.C.</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>W. J. Jeffers #642</i>				22. NAME AND ADDRESS OF FACILITY <i>Fraziers Funeral Home, Inc. 389 Rhode Island Av., NW, Washington, D.C.</i>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Complications of hip replacement</i> (DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Multiple right hip surgery since 1980, Dec. 6</i> <i>Auto accident</i>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Augusto P. Rodriguez MD</i>				29c. LICENSE NUMBER <i>D21230</i>		29d. DATE SIGNED (Month, Day, Year) <i>October 17, 1994</i>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Augusto P. Rodriguez MD, 5009 Rayburn Ct. Cap. Spr. Md 20748</i>									
31. DATE FILED (Month, Day, Year) <i>OCT 24 1994</i>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

3

94 33570

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HENRY JEFFERSON				2. DATE OF DEATH MONTH 10 DAY 19 YEAR 94		3. TIME OF DEATH 11:45 M	
4. SOCIAL SECURITY NUMBER 578 74 0720		5. SEX 1 M 2 F		6. AGE (In yrs. last birthday) 39 YRS.		7. DATE OF BIRTH (Month, Day, Year) 1 28 55	
8. BIRTHPLACE (State or Foreign Country) WASHINGTON D				9a. FACILITY NAME (If not institution, give street and number) HYATTSVILLE MANOR CARE		9b. CITY, TOWN OR LOCATION OF DEATH HYATTSVILLE	
9c. COUNTY OF DEATH PRINCE GEORGES				10a. STATE D.C.		10b. COUNTY WASHINGTON	
10c. CITY, TOWN OR LOCATION WASHINGTON				10d. INSIDE CITY LIMITS? 1 YES 2 NO		10e. STREET AND NUMBER 401 CHAPLIN ST., S.E. #110	
10f. ZIP CODE 20019				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9th		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) UNEMPLOYED		16b. KIND OF BUSINESS/INDUSTRY NONE			
17. FATHER'S NAME (First, Middle, Last) HENRY JEFFERSON				18. MOTHER'S NAME (First, Middle, Maiden Surname) VIRGINIA FRANCES MASON			
19a. INFORMANT'S NAME (Type/Print) VIRGINIA KEITH				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 401 CHAPLIN ST., S.E. #110 WASH. D.C. 20019			
20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) LINCOLN MEMORIAL CEM. 10/24/94 SUITLAND, MD.		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Belna J. Jenkins				22. NAME AND ADDRESS OF FACILITY JOHNSON & JENKINS INC. 716 KENNEDY ST., N.W. WASH. D.C. 20011			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → cardio respiratory Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST hypertension failure wasting syndrome acquired immune deficiency syndrome PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. none							
24. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO							
25. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DCA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)					
27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 8 Nomicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 YES 2 NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]				29c. LICENSE NUMBER DO1999		29d. DATE SIGNED (Month, Day, Year) 10/19/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) OCT 25 1994				32. REGISTRAR'S SIGNATURE [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

5

Amended #14

10/26/94

P.G. Health Dept,

A.U.

94 33571

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) WILLIAM C. JENSEN				2. DATE OF DEATH MONTH DAY YEAR 10 10 94		3. TIME OF DEATH 11:20 A.M.	
4. SOCIAL SECURITY NUMBER NONE		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. MONTHS DAYS 0 0 15		7. DATE OF BIRTH (Month, Day, Year) 10 9 94	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) St. Agnes Hosp.		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH Baltimore				10a. STATE Maryland		10b. COUNTY Prince Georges	
10c. CITY, TOWN OR LOCATION Bowie, Md.				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 12210 Roundtree Ln.	
10f. ZIP CODE 20715				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black/white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) NA College (1-4 pr 5+) NA				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) NA		16b. KIND OF BUSINESS/INDUSTRY NA	
17. FATHER'S NAME (First, Middle, Last) James JENSEN, Jr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Alexa HENSON			
19a. INFORMANT'S NAME (Type/Print) Alexa HENSON JENSEN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12210 Roundtree Ln. Bowie, Md. 20715			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Harmony Mem. Park 10/13/94		20c. LOCATION — City or Town, State Landover, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Darryl St. Grant				22. NAME AND ADDRESS OF FACILITY H.S. Washington & Sons, Inc. 4925 Burroughs Ave., N.E.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. PULMONARY INTERSTITIAL EMPHYSEMA							
DUE TO (OR AS A CONSEQUENCE OF):							
b. RESPIRATORY DISTRESS SYNDROME							
DUE TO (OR AS A CONSEQUENCE OF):							
c. IMMATURITY							
DUE TO (OR AS A CONSEQUENCE OF):							
d. PRE TERM BIRTH							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Arturo Q. Santos, MD				29c. LICENSE NUMBER D14955		29d. DATE SIGNED (Month, Day, Year) 10/10/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ARTURO Q. SANTOS, MD 900 Caton Ave. Baltimore, Md. 21229							
31. DATE FILED (Month, Day, Year) OCT 26 1994				32. REGISTRAR'S SIGNATURE J. Davidson-Mandell			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit form. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33572

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Helen Jackson				2. DATE OF DEATH MONTH DAY YEAR 10 30 94		3. TIME OF DEATH 5:40 P.M.	
4. SOCIAL SECURITY NUMBER 213-26-0129		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 84 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10-18-10	
8. FACILITY NAME (If not institution, give street and number) CATON MANOR Meridian				9a. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH MD	
10a. STATE MARYLAND				10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION BALTIMORE	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 11 W. 20th STREET			
10f. ZIP CODE 21218				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) DOMESTIC				16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SOME ONE ELSE HOME			
17. FATHER'S NAME (First, Middle, Last) ABRAHAM WALLACE				18. MOTHER'S NAME (First, Middle, Maiden Surname) EVA CREEK			
19a. INFORMANT'S NAME (Type/Print) JAMES WALLACE				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 404 CHESTER AVENUE ANNAPOLIS, MD. 21403			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ANNAPOLIS MEM. GARDENS 11/4/94		DATE 11/4/94		20c. LOCATION — City or Town, State ANNAPOLIS, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Barry H. Reese</i>				22. NAME AND ADDRESS OF FACILITY REESE & SONS MORTUARY, P.A. 821 WEST STREET ANNAPOLIS, MD. 21401			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → probable cardiac arrhythmia minutes Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated event resulting in death) LAST { congestive heart failure diabetic cardiomyopathy Approximate Interval Between Onset and Death complex years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. V. Skarbek, M.D.</i>				29c. LICENSE NUMBER D29767		29d. DATE SIGNED (Month, Day, Year) 10/31/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. V. Skarbek, M.D. 8418 B+A BLVD. Pasadena, Md. 21122							
31. DATE FILED (Month, Day, Year) NOV 03 1994				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transmission permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Handwritten text, possibly a date or reference number, located in the upper right quadrant of the page.

Main body of handwritten text, appearing to be a list or a series of notes, located in the center of the page. The text is mostly illegible due to fading.

A small handwritten mark or symbol, possibly a cross or a small 'x', located below the main body of text.

A small handwritten mark or symbol, possibly a cross or a small 'x', located in the lower right quadrant of the page.

Bottom section of handwritten text, possibly a conclusion or a signature, located at the bottom of the page. The text is mostly illegible.

Amended #1, Nov. 9, 1994, FS, Wash. Co. Health 94 33573

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) WILLIAM WEBSTER KNODE				2. DATE OF DEATH MONTH 11 DAY 4 YEAR 94		3. TIME OF DEATH 8:04 a.m.	
4. SOCIAL SECURITY NUMBER 214-09-5327		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 88 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct. 7, 1906	
9a. FACILITY NAME (If not institution, give street and number) Colton Villa Nursing Center				9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown		9c. COUNTY OF DEATH Washington	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Chewsville		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 21201 Twin Springs Drive				10f. ZIP CODE 21721		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) foreman		16b. KIND OF BUSINESS/INDUSTRY shoe mfg.			
17. FATHER'S NAME (First, Middle, Last) John Vincent Knode				18. MOTHER'S NAME (First, Middle, Maiden Surname) Eva Bender			
19a. INFORMANT'S NAME (Type/Print) Nancy L. Ward				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 124 Westway #T-1, Greenbelt, Md. 20770			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. View Cemetery 11-7-94		20c. LOCATION — City or Town, State Sharpsburg, Maryland		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Scott Minnich				22. NAME AND ADDRESS OF FACILITY MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. CHRONIC OBSTRUCTIVE AIRWAY DISEASE 20 years					
		b. PNEUMONIA 1 week					
		c. DEMENTIA 2 years					
		d. ATHEROSCLEROTIC CARDIAC DISEASE 2 years					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) N/A		28b. TIME OF INJURY N/A		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED N/A				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) N/A			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. DATE SIGNED (Month, Day, Year) 11.4.94			
29. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Raymond J. Rap...				29c. LICENSE NUMBER D28365		29d. DATE SIGNED (Month, Day, Year)	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 368 MILL STREET HAGERSTOWN MD 21740							
31. DATE FILED (Month, Day, Year) NOV 07 1994				32. REGISTRAR'S SIGNATURE John Sander-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

THE COMMONWEALTH

OF MASSACHUSETTS

1880



RECEIVED OF THE COMMISSIONER OF THE LAND OFFICE
THE COMMONWEALTH OF MASSACHUSETTS
FOR THE YEAR 1880

Received of the Treasurer of the Commonwealth
the sum of \$100.00
for the year 1880

THE COMMONWEALTH

OF MASSACHUSETTS

1880

1880

94 33574

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Christopher Michael Kent</u>				2. DATE OF DEATH MONTH <u>10</u> DAY <u>31</u> YEAR <u>94</u>		3. TIME OF DEATH <u>1050 A.M.</u>	
4. SOCIAL SECURITY NUMBER <u>219-88-9326</u>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>33</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>5 May 1961</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>Washington Co. Hospital</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Hagerstown</u>		9c. COUNTY OF DEATH <u>Washington</u>	
10a. STATE <u>Maryland</u>		10b. COUNTY <u>Washington</u>		10c. CITY, TOWN OR LOCATION <u>Hagerstown</u>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <u>31 West Bethel Street</u>				10f. ZIP CODE <u>21740</u>		10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>Black</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>Twelve (12TH)</u> College (14 or 5+) <u>Caterer</u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Caterer</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Food Service</u>			
17. FATHER'S NAME (First, Middle, Last) <u>Lloyd Edward Simmons</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Mary Catherine Jackson</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Deborah Simmons</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>31 W. Bethel ST. Hagerstown, MD 21740</u>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Rose Hill 11/5/94</u>		20c. LOCATION — City or Town, State <u>Hagerstown, MD</u>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Thomas E. Watts</u>				22. NAME AND ADDRESS OF FACILITY <u>22 W. Bethel St. Hagerstown, MD 21740</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Myocardial infarction, Cardiac arrest</u> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <u>Severe Metabolic Acidosis</u> <u>Renal Failure</u> <u>Advanced HIV infection</u> Approximate Interval Between Onset and Death <u>Months</u> <u>Days</u> <u>Days</u> <u>Years</u>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/></u>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Martin W. Gallagher MD</u>				29c. LICENSE NUMBER <u>D31880</u>		29d. DATE SIGNED (Month, Day, Year) <u>11/1/94</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Martin W. Gallagher Skm 1110 Medina / Campus Rd Hagerstown</u>							
31. DATE FILED (Month, Day, Year) <u>NOV 02 1994</u>				32. REGISTRAR'S SIGNATURE <u>Julius Simon-Randall</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33575

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Harold Theodore Keyser II</i>				2. DATE OF DEATH MONTH <i>10</i> DAY <i>30</i> YEAR <i>1994</i>				3. TIME OF DEATH <i>2320</i> M	
4. SOCIAL SECURITY NUMBER <i>212-66-9092</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>32</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>7/15/1962</i>		8. BIRTHPLACE (State or Foreign Country) <i>Hagerstown, MD</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Washington County Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Hagerstown</i>				9c. COUNTY OF DEATH <i>Washington</i>	
RESIDENCE OF DECEDENT									
10a. STATE <i>MD</i>		10b. COUNTY <i>Frederick</i>		10c. CITY, TOWN OR LOCATION <i>Sabillasville</i>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>14704 Herman Hauver RD</i>				10f. ZIP CODE <i>21780</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify <i>White</i>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i></i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Plumber</i>			16b. KIND OF BUSINESS/INDUSTRY <i>Plumbing & Heating Contractor</i>		
17. FATHER'S NAME (First, Middle, Last) <i>Harold T. Keyser</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Margaret Ann Kuhn</i>					
19a. INFORMANT'S NAME (Type/Print) <i>Harold T. Keyser</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>14704 Herman Hauver RD, Sabillasville, MD 21780</i>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Green Hill Cemetery</i>		DATE <i>11/3</i>		20c. LOCATION — City or Town, State <i>Waynesboro, PA 17268</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James P. Boulanger</i>				22. NAME AND ADDRESS OF FACILITY <i>Grove Funeral Home, Inc. 50 S. Broad ST., Waynesboro, PA 17268</i>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Had trauma due to</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Auto accident</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i></i> DUE TO (OR AS A CONSEQUENCE OF): d. <i></i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <i>10/30/94</i>		28b. TIME OF INJURY <i>2215</i> M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED <i>Ran into telephone pole</i>	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <i>MD State Rt 550</i>				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <i>Washington Co. MD.</i>					
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <i>D26806</i>		29d. DATE SIGNED (Month, Day, Year) <i>10/31/94</i>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>ADD 742 Norton Ave Hagerstown MD 21742</i>									
31. DATE FILED (Month, Day, Year) <i>NOV 03 1994</i>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33576

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Helen Irene Kipe</i>				2. DATE OF DEATH MONTH DAY YEAR <i>November 3, 1994</i>		3. TIME OF DEATH <i>0946</i>	
4. SOCIAL SECURITY NUMBER <i>214-16-0920</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>77</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>June 18, 1917</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Washington County Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Hagerstown</i>		9c. COUNTY OF DEATH <i>Washington</i>	
10a. STATE <i>Maryland</i>				10b. COUNTY <i>Washington</i>		10c. CITY, TOWN OR LOCATION <i>Hagerstown</i>	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <i>11403 Stonecroft Court, Apt. 101A</i>				10f. ZIP CODE <i>21742</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>white</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>8</i> College (1-4 or 5+) <i>0</i>		18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>cafeteria</i>		18b. KIND OF BUSINESS/INDUSTRY <i>food service</i>			
17. FATHER'S NAME (First, Middle, Last) <i>John A. Crampton</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Cora Belle Myers</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Michael J. Kipe</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>11103 Lakeside Dr., Hagerstown, Md. 21740</i>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Rest Haven Cemetery 11-7-94</i>		20c. LOCATION — City or Town, State <i>Hagerstown, Maryland</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Scott M. Minnich</i>				22. NAME AND ADDRESS OF FACILITY <i>MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Myocardial infarction</i> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Arteriosclerotic cardiovascular disease</i> PART II. Other significant conditions contributing to death but not resulting in the underlying causes given in Part I. <i>Hypertension Diabetes mellitus Hypercholesterolemia</i> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							Approximate Interval Between Onset and Death <i>years</i>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. PLACE OF DEATH (Check only one) OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <i>D26806</i>		29d. DATE SIGNED (Month, Day, Year) <i>11/3/94</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Alan D. Bix MD 147 Northern Ave Hagerstown MD 21742</i>							
31. DATE FILED (Month, Day, Year) <i>NOV 04 1994</i>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33577

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) DOROTHY LUCINDA KARN				2. DATE OF DEATH MONTH 11 DAY 3 YEAR 94		3. TIME OF DEATH 1:20 a.m.	
4. SOCIAL SECURITY NUMBER 214-32-4572		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 89 YRS.		7. DATE OF BIRTH (Month, Day, Year) DEC. 5, 1904	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) COLTON VILLA NURSING HOME		9b. CITY, TOWN OR LOCATION OF DEATH HAGERSTOWN	
9c. COUNTY OF DEATH WASHINGTON				10a. STATE MARYLAND		10b. COUNTY WASHINGTON	
10c. CITY, TOWN OR LOCATION HAGERSTOWN				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 328 DEVONSHIRE ROAD	
10f. ZIP CODE 21740				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 YEARS College (1-4 or 5+) _____				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER		16b. KIND OF BUSINESS/INDUSTRY PERSONAL RESIDENCE	
17. FATHER'S NAME (First, Middle, Last) DANIEL ANDREW GAYLOR				18. MOTHER'S NAME (First, Middle, Maiden Surname) ALICE I. SMITH			
19a. INFORMANT'S NAME (Type/Print) EDNA MAYETTA ROBY				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17962 GARDEN LANE APT 3 HAGERSTOWN, MARYLAND 21742			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) REST HAVEN CEMETERY NOV. 5, 1994		20c. LOCATION — City or Town, State HAGERSTOWN, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE DOUGLAS A. FIERY				22. NAME AND ADDRESS OF FACILITY DOUGLAS A. FIERY FUNERAL HOME 21742 1331 EASTERN BLVD., NORTH HAGERSTOWN, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ALZHEIMER DISEASE DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. CONGESTIVE HEART FAILURE DUE TO (OR AS A CONSEQUENCE OF): c. SEPSIS DUE TO (OR AS A CONSEQUENCE OF): d. X Approximate Interval Between Onset and Death 34 years 4 years 24 hrs							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) N/A		28b. TIME OF INJURY N/A	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED N/A		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) N/A	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) NA				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER Manu J. Ray				29c. LICENSE NUMBER D28365		29d. DATE SIGNED (Month, Day, Year) 11/3/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 368 MILL STREET HAGERSTOWN MD 21740							
31. DATE FILED (Month, Day, Year) NOV 04 1994				32. REGISTRAR'S SIGNATURE John D. ...			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 may be retained by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

THE NATIONAL ARCHIVES

RECORDS SECTION



94 33578

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Charles E Kretzer Sr</u>				2. DATE OF DEATH MONTH <u>NOV</u> DAY <u>3</u> YEAR <u>1994</u>		3. TIME OF DEATH <u>1345</u> M	
4. SOCIAL SECURITY NUMBER <u>214-09-8936</u>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		8. AGE (In yrs. last birthday) <u>78</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>7-26-16</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>Washington County Hospital</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Hagerstown Md</u>		9c. COUNTY OF DEATH <u>Washington</u>	
10a. STATE <u>Maryland</u>				10b. COUNTY <u>Washington</u>		10c. CITY, TOWN OR LOCATION <u>Hagerstown</u>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER <u>11 W. Baltimore St.</u>			
10f. ZIP CODE <u>21740</u>				10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <u>WWII</u>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>8</u> College (1-4 or 5+) <u></u>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>sheet metal worker</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Equip. Manufacturer</u>	
17. FATHER'S NAME (First, Middle, Last) <u>Charles Walter Kretzer</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Margaret Ann Dobson</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Janet M. Swope</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>7856 Fairplay Rd. Fairplay, MD 21733</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Mt. View Cemetery Nov. 7, 1994</u>		20c. LOCATION — City or Town, State <u>Sharpsburg, Maryland</u>		22. NAME AND ADDRESS OF FACILITY <u>Osborne Funeral Home 21795 425 S. Conococheague St. Williamsport, MD</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>[Signature]</u>				22. NAME AND ADDRESS OF FACILITY <u>Osborne Funeral Home 21795 425 S. Conococheague St. Williamsport, MD</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		<u>CARCINOMA OF LUNG</u>				Approximate Interval Between Onset and Death <u>JULY, 1994</u>	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		<u>Hypertension</u>				UNKNOWN	
		<u>Anaemia</u>				UNKNOWN	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Mark Jameson MD</u>				29c. LICENSE NUMBER <u>031537</u>		29d. DATE SIGNED (Month, Day, Year) <u>11/3/94</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>MARK JAMESON WASHINGTON CO. HOSPITAL, HAGERSTOWN, MD 21740</u>							
31. DATE FILED (Month, Day, Year) <u>NOV 04 1994</u>				32. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33579

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Albert R. King				2. DATE OF DEATH MONTH DAY YEAR October 24, 1994		3. TIME OF DEATH 8:30 AM	
4. SOCIAL SECURITY NUMBER 218-10-7343		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 76 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov 18, 1917	
9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1135 University Blvd West Apt#1103				10f. ZIP CODE 20902		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7th Grade College (1-4 or 5+) None		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Laborer		16b. KIND OF BUSINESS/INDUSTRY None			
17. FATHER'S NAME (First, Middle, Last) Frank King				18. MOTHER'S NAME (First, Middle, Maiden Surname) Selina Thomas			
19a. INFORMANT'S NAME (Type/Print) Mrs Mary Brown(Sister)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14635 Bauer Drive, Rockville, Md 20853			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 10/29 Alexandria, Va		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George R. Snowden</i>				22. NAME AND ADDRESS OF FACILITY Snowden Funeral Home P.A. 20850 246 N. Washington St, Rockville, Md			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. coronary artery disease DUE TO (OR AS A CONSEQUENCE OF): b. congestive Heart failure DUE TO (OR AS A CONSEQUENCE OF): c. Aortic stenosis DUE TO (OR AS A CONSEQUENCE OF): d. Adult onset Diabetes							Approximate interval between Onset and Death 75yrs 75yrs 75yrs 710yrs
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Hyperlipidemia							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE NOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>S. Sudhakar MD</i>				29c. LICENSE NUMBER D 35792		29d. DATE SIGNED (Month, Day, Year) 10/24/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) S. SUDHAKAR 50 W. EDMONSTON DR. ROCKVILLE, MD 20850							
31. DATE FILED (Month, Day, Year) OCT 26 1994				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020



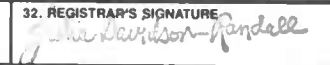
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 may be retained by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 may be retained by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33580

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mary Korson				2. DATE OF DEATH MONTH DAY YEAR OCT. 23 94		3. TIME OF DEATH 10:57A M	
4. SOCIAL SECURITY NUMBER 577-03-8549		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 82 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 10, 1912	
8. BIRTHPLACE (State or Foreign Country) Washington, D.C.				9a. FACILITY NAME (If not institution, give street and number) 13604 Castlecliff Way		9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring	
9c. COUNTY OF DEATH Montgomery				10a. STATE Florida		10b. COUNTY Martin	
10c. CITY, TOWN OR LOCATION Stuart				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 4684 S.E. Teri Place	
10f. ZIP CODE 34997				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4th College (1-4 or 5+) 0				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Clerk		16b. KIND OF BUSINESS/INDUSTRY Retail Foods	
17. FATHER'S NAME (First, Middle, Last) Salvatore Fusco				18. MOTHER'S NAME (First, Middle, Maiden Surname) Rosina Cuzzo			
19a. INFORMANT'S NAME (Type/Print) Rosemary McAvoy				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4684 S.E. Teri Place Stuart, FL 34997			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Mausoleum 10/26 Brentwood, Maryland		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiovascular Disease Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER DO2546		29d. DATE SIGNED (Month, Day, Year) OCT 23 94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John I. Corbin 218 Wisconsin Ave Bethesda							
31. DATE FILED (Month, Day, Year) OCT 25 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.


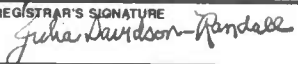
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33581

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JUANITA ELIZABETH KING				2. DATE OF DEATH MONTH DAY YEAR OCTOBER 18, 1994		3. TIME OF DEATH 1:48 P M	
4. SOCIAL SECURITY NUMBER 577-58-6935		5. SEX 1 M 2 F	6. AGE (In yrs. last birthday) 50 YRS.	IF UNDER 1 YEAR MONTHS DAY	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) OCT 16, 1944	
9a. FACILITY NAME (If not institution, give street and number) 4264 SUITLAND ROAD #103				9b. CITY, TOWN OR LOCATION OF DEATH SUITLAND		9c. COUNTY OF DEATH PRINCE GEORGES	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY PRINCE GEORGES		10c. CITY, TOWN OR LOCATION SUITLAND		10d. INSIDE CITY LIMITS? 1 YES 2 NO	
10e. STREET AND NUMBER 4264 SUITLAND ROAD #103				10f. ZIP CODE 20746		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES	
11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 10		15e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SUPERVISOR		16b. KIND OF BUSINESS/INDUSTRY GOVERNMENT			
17. FATHER'S NAME (First, Middle, Last) JAMES HARRIS				18. MOTHER'S NAME (First, Middle, Maiden Surname) HATTIE JONES			
19a. INFORMANT'S NAME (Type/Print) ANITA HARRIS (DAUGHTER)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4264 SUITLAND RD #103 SUITLAND, MD 20747			
20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HARMONY MEMORIAL PARK 10/24		20c. LOCATION — City or Town, State LANDOVER, MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  M859				22. NAME AND ADDRESS OF FACILITY ALEXANDER S. POPE FUNERAL HOMES 5538 MARLBORO PIKE, FORESTVILLE, MD 20747			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Multiple sclerosis							
24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)					
27. MANNER OF DEATH 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 YES 2 NO	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Alfonso Valle M.D.				29c. LICENSE NUMBER D12879		29d. DATE SIGNED (Month, Day, Year) OCT 19, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ALFONSO VALLE M.D. 10701 TRANTON DR., LARGO, MD 20772							
31. DATE FILED (Month, Day, Year) OCT 24 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33582

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) CHARLES FREDERICK KISER				2. DATE OF DEATH MONTH OCTOBER DAY 25 YEAR 94		3. TIME OF DEATH 7:15 A M	
4. SOCIAL SECURITY NUMBER 212-14-2534		5. SEX 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 71 YRS.	IF UNDER 1 YEAR MONTHS DAY	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Nov. 24, 1922	
8. BIRTHPLACE (State or Foreign Country) West Virginia				9a. FACILITY NAME (If not institution, give street and number) Prince George's Hospital Center		9b. CITY, TOWN OR LOCATION OF DEATH Cheverly	
9c. COUNTY OF DEATH Prince George's				10a. STATE Maryland		10b. COUNTY Prince George's	
10c. CITY, TOWN OR LOCATION Riverdale				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER 5415 #2 56th Avenue				10f. ZIP CODE 20737		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Unavailable		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Disabled		16b. KIND OF BUSINESS/INDUSTRY Unavailable			
17. FATHER'S NAME (First, Middle, Last) Andrew Jackson Kiser				18. MOTHER'S NAME (First, Middle, Maiden Surname) Victoria (Maiden Name Unavailable)			
19a. INFORMANT'S NAME (Type/Print) Jack Ramsey				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5415 #2 56th Avenue, Riverdale, Maryland 20737			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arlington National Cem. 11/2/94		DATE 11/2/94		20c. LOCATION — City or Town, State Arlington, Virginia	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. <i>Respiratory Failure</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>Chronic obstructive Pulmonary Disease</i> DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death <i>None</i> <i>Over 2 weeks</i> <i>Yes</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Coronary vessel insufficiency. Urinary tract disease. Peripheral Vascular disease. Left (Hypertension) artery.</i>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		29i. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER D10220		29d. DATE SIGNED (Month, Day, Year) 10/25/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Fredrick H. Wilkins, 5407 Annapolis Rd. Hyattsville, Maryland 20784							
31. DATE FILED (Month, Day, Year) OCT 28 1994							

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 7 and 8 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33583

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JOHN HENRY KELLY				2. DATE OF DEATH MONTH DAY YEAR October 23, 1994		3. TIME OF DEATH 12:02 A M	
4. SOCIAL SECURITY NUMBER 579-40-4338		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) October 16, 1911	
9a. FACILITY NAME (If not institution, give street and number) Washington Adventist Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Takoma Park		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION University Park		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 4401 Tuckerman Street				10f. ZIP CODE 20782		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) College (1-4 or 5+) 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Unavailable		16b. KIND OF BUSINESS/INDUSTRY Defense Intelligence Agency			
17. FATHER'S NAME (First, Middle, Last) John H. Kelly, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Marie Frank			
19a. INFORMANT'S NAME (Type/Print) Janet H. Kelly				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4401 Tuckerman Street, University Park, MD 20782			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Cemetery 10/26/94		20c. LOCATION — City or Town, State Brentwood, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE W.B. Gaiser				22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Myocardial Infarction b. atherosclerotic cardiovascular disease c. d. Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death 2 hours
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Renal Failure							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature] MD				29c. LICENSE NUMBER D-18089		29d. DATE SIGNED (Month, Day, Year) 10/24/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Steven M Pollack MD 7525 Greenway CTR dring Greenbelt							
31. DATE FILED (Month, Day, Year) OCT 25 1994				32. REGISTRAR'S SIGNATURE John Davidson-Randall			

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

94 33584

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) WILLIAM R. KELTY, III.				2. DATE OF DEATH MONTH OCT DAY 23 YEAR 1994		3. TIME OF DEATH 10:45PM M	
4. SOCIAL SECURITY NUMBER 212-68-0972		5. SEX 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 35 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb. 20, 1959	
9a. FACILITY NAME (If not institution, give street and number) Prince George's Hospital Center				9b. CITY, TOWN OR LOCATION OF DEATH Cheverly		9c. COUNTY OF DEATH Prince George's	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Brentwood		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 3602 42nd Avenue				10f. ZIP CODE 20722		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Bar Tender		16b. KIND OF BUSINESS/INDUSTRY Private	
17. FATHER'S NAME (First, Middle, Last) William R. Kelty, Jr.				16. MOTHER'S NAME (First, Middle, Maiden Surname) Dorothy P. Houser			
19a. INFORMANT'S NAME (Type/Print) William R. Kelty, Jr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) H.C. 60, Box 159-1a, Slanesville, West Virginia 25444			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 10/25/94		20c. LOCATION — City or Town, State Alexandria, Virginia			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>W.B. Gesser</i>				22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sepsis - Wasting and AIDS related comp. DUE TO (OR AS A CONSEQUENCE OF): AIDS Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): same c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jaleh Daez, M.D.</i>				29c. LICENSE NUMBER D32761		29d. DATE SIGNED (Month, Day, Year) 10-24-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Jaleh-DAEE, M.D.							
31. DATE FILED (Month, Day, Year) OCT 26 1994				32. REGISTRAR'S SIGNATURE <i>Jane Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33585

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Lillie Kelly</i>				2. DATE OF DEATH MONTH DAY YEAR 10-21-94		3. TIME OF DEATH 5:30 A. M.	
4. SOCIAL SECURITY NUMBER 579-34-3965		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 65 YRS.	7. DATE OF BIRTH (Month, Day, Year) 11-11-28	8. BIRTHPLACE (State or Foreign Country) Ohio		
9a. FACILITY NAME (If not institution, give street and number) Kensington Gardens Nursing Center				9b. CITY, TOWN OR LOCATION OF DEATH Kensington		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Kensington		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 3000 McComas Avenue				10f. ZIP CODE 20895		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Negro	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12th College (1-4 or 5+) College		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) PTC Nurse		15b. KIND OF BUSINESS/INDUSTRY Government			
17. FATHER'S NAME (First, Middle, Last) Thomas Jamison				18. MOTHER'S NAME (First, Middle, Maiden Surname) Callie Mae Turnipseed			
19a. INFORMANT'S NAME (Type/Print) Quinton M. Bowie				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 310 R.I. Avenue N.E., Wash. D.C. 20002			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Ft. Lincoln Cemetery 10/26/94 Brentwood, Md.		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John T. Stewart, III</i>				22. NAME AND ADDRESS OF FACILITY STEWART FUNERAL HOME 4001 Benning Rd. N.E., Wash. D.C.			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. <i>Stroke, presumed</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>ASCVD</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>diabetes mellitus</i> <i>peripheral vascular disease, prior stroke</i> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>David A. Blass, M.D.</i>				29c. LICENSE NUMBER D23911		29d. DATE SIGNED (Month, Day, Year) 10/21/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David A. Blass, M.D. 9410 Old Georgetown Road, Bethesda, Md. 20814							
31. DATE FILED (Month, Day, Year) OCT 27 1994				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

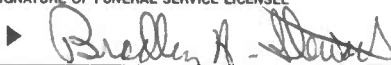

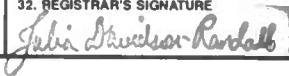
TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

94 33586

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Paul Elwood LILLER, Sr.				2. DATE OF DEATH MONTH DAY YEAR Oct. 12, 1994		3. TIME OF DEATH 12:10 A M	
4. SOCIAL SECURITY NUMBER 236-42-0245		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 65 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan. 14, 1929	
9a. FACILITY NAME (If not institution, give street and number) Rt. 2, Box 2952				9b. CITY, TOWN OR LOCATION OF DEATH Oakland		9c. COUNTY OF DEATH Garrett	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY Garrett		10c. CITY, TOWN OR LOCATION Oakland		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER Rt. 2, Box 2952				10f. ZIP CODE 21550		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1951-52		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8				18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Coal Miner		16b. KIND OF BUSINESS/INDUSTRY Coal Mining	
17. FATHER'S NAME (First, Middle, Last) Paul ----- Liller				18. MOTHER'S NAME (First, Middle, Maiden Surname) Bessie Jane Reall			
19a. INFORMANT'S NAME (Type/Print) Velma Liller				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt. 2, Box 2952, Oakland, Maryland 21550			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fairview Cemetery		DATE 10/14		20c. LOCATION — City or Town, State Oakland, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Stewart Funeral Home 32 S. Second St., Oakland, MD 21550			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. congestive heart failure DUE TO (OR AS A CONSEQUENCE OF): b. ASHD with ischemia DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death months years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPD BPH DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE NOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D15333		29d. DATE SIGNED (Month, Day, Year) 10/14/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Thomas Johnson, MD 311 N. Fourth St., Oakland, Maryland 21550							
31. DATE FILED (Month, Day, Year) OCT 19 1994		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit form and be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

3
416A

Amended #1, Nov. 07, 1994, FS, Wash. Co. Health Dept. 94 33587

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>DAVID J LANN SOLOMAN DAVID DEWESE LINN</i>				2. DATE OF DEATH MONTH DAY YEAR <i>11 03 94</i>		3. TIME OF DEATH <i>9:17 PM</i>	
4. SOCIAL SECURITY NUMBER <i>177-24-8141</i>		5. SEX <i>1 M 2 F</i>		6. AGE (In yrs. last birthday) <i>60</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Feb. 7, 1934</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Pennsylvania</i>				9a. FACILITY NAME (If not institution, give street and number) <i>Washington County Hospital</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Hagerstown</i>	
9c. COUNTY OF DEATH <i>Washington</i>				10a. STATE <i>Maryland</i>		10b. COUNTY <i>Washington</i>	
10c. CITY, TOWN OR LOCATION <i>Hagerstown</i>				10d. INSIDE CITY LIMITS? <i>1 YES 2 NO</i>		10e. STREET AND NUMBER <i>701 Knight Bridge Drive #2</i>	
10f. ZIP CODE <i>21740</i>				10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		11. MARITAL STATUS <i>1 Never Married 2 Married 3 Widowed 4 Divorced</i>	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <i>1 YES 2 NO</i> IF YES, GIVE WAR OR DATES <i>Korean-Vietnam</i>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <i>1 YES 2 NO</i>		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>Elementary/Secondary (0-12) 12</i>				16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Computer Operator</i>		17. KIND OF BUSINESS/INDUSTRY <i>Government</i>	
17. FATHER'S NAME (First, Middle, Last) <i>Howard Cleveland Linn</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Edna Ruth Gamble</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Cynthia Linn</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>911-C Main Avenue Hagerstown, Maryland 21740</i>			
20a. METHOD OF DISPOSITION <i>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</i>				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Greenlawn Memorial Park 11-7-94</i>		20c. LOCATION — City or Town, State <i>Williamsport, Md.</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Scott M Minnick</i>				22. NAME AND ADDRESS OF FACILITY <i>Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Acute Myocardial Infarction</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Some coronary artery disease</i>							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Some chronic obstructive pulmonary disease</i>							24a. WAS AN AUTOPSY PERFORMED? <i>1 YES 2 NO</i>
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <i>1 YES 2 NO</i>							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <i>1 YES 2 NO</i>				26. PLACE OF DEATH (Check only one) HOSPITAL: <i>1 Inpatient 2 ER/Outpatient 3 DOA</i> OTHER: <i>4 Nursing Home 5 Residence 6 Other (Specify)</i>			
27. MANNER OF DEATH <i>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</i>				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>	
28c. INJURY AT WORK? <i>1 YES 2 NO</i>				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <i>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</i> <i>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</i>							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <i>6604</i>		29d. DATE SIGNED (Month, Day, Year) <i>11-5-94</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 2) (Type, Print) <i>E L Ladd 382 John Chatham Dr. Hagerstown, Md 21740</i>							
31. DATE FILED (Month, Day, Year) <i>NOV 07 1994</i>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33588

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Tillie B. Lewis				2. DATE OF DEATH MONTH OCTOBER DAY 24 YEAR 1994		3. TIME OF DEATH 11p M	
4. SOCIAL SECURITY NUMBER 213-74-5634		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 95 YRS.		7. DATE OF BIRTH (Month, Day, Year) NOV. 20, 1898	
9a. FACILITY NAME (If not institution, give street and number) HOLY CROSS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH SILVER SPRING		9c. COUNTY OF DEATH MONTGOMERY	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY MONTGOMERY		10c. CITY, TOWN OR LOCATION SILVER SPRING		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 8201 16TH. STREET, #1218				10f. ZIP CODE 20910		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER		16b. KIND OF BUSINESS/INDUSTRY OWN HOME			
17. FATHER'S NAME (First, Middle, Last) ABRAHAM BLOOM				18. MOTHER'S NAME (First, Middle, Maiden Surname) GOLDIE KOREN			
19a. INFORMANT'S NAME (Type/Print) HELEN TEBELEFF				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9713 ADMIRALTY DRIVE-SILVER SPRING, MD. 20910			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) B'NAI ISRAEL CONG. CEMETERY 10/26		20c. LOCATION — City or Town, State OXON HILL, MARYLAND		22. NAME AND ADDRESS OF FACILITY DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE - ROCKVILLE, MD. 20852	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Barth J. Isaac</i>				22. NAME AND ADDRESS OF FACILITY DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE - ROCKVILLE, MD. 20852			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. pneumonia DUE TO (OR AS A CONSEQUENCE OF): b. dementia DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD				29c. LICENSE NUMBER D35703		29d. DATE SIGNED (Month, Day, Year) 10/25/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Stephen Vaccarezza 6240 Monroe Rd Rockville MD 20852							
31. DATE FILED (Month, Day, Year) OCT 27 1994				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Form 8-1017

THE HIGHER EDUCATION

THE HIGHER EDUCATION

THE HIGHER EDUCATION

THE HIGHER EDUCATION

5

94 33589

Amended # 100, 206, 10/28/94, J.W., Montgomery Co.

1 -
FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) MARIANNE PIERRE-LOUIS				2. DATE OF DEATH MONTH 10 DAY 27 YEAR 1994		3. TIME OF DEATH 4:00AM M	
4. SOCIAL SECURITY NUMBER 578-72-6335		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) November 28, 1910	
8. BIRTHPLACE (State or Foreign Country) Haiti		9a. FACILITY NAME (If not institution, give street and number) 6503 Dawnwood Drive		9b. CITY, TOWN OR LOCATION OF DEATH Lanham		9c. COUNTY OF DEATH Prince Georges	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Prince Georges		10c. CITY, TOWN OR LOCATION Lanham-Lanham		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 6503 Dawnwood Drive				10f. ZIP CODE 20706		10g. CITIZEN OF WHAT COUNTRY? Haiti	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		15b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) Jean Duron Jean Baptist				18. MOTHER'S NAME (First, Middle, Maiden Surname) Suzanne Jasperd			
19a. INFORMANT'S NAME (Type/Print) Mona F. Agnant				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6503 Dawnwood Drive Lanham, Maryland 20706			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 10/28/94		20c. LOCATION — City or Town, State Silver Spring, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Stern Stern				22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr. MD 20901			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute myocardial infarction DUE TO (OR AS A CONSEQUENCE OF): b. Congestive heart failure DUE TO (OR AS A CONSEQUENCE OF): c. Coronary artery disease DUE TO (OR AS A CONSEQUENCE OF): d. Coronary atherosclerosis Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic renal insufficiency, Diabetes mellitus, Anemia, Hypertension & Hypertensive cardiovascular disease.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER J. J. J. J.				29c. LICENSE NUMBER D24720		29d. DATE SIGNED (Month, Day, Year) 10/27/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 6132 Landover Rd, Chertsey Md 20785							
31. DATE FILED (Month, Day, Year) OCT 28 1994				32. REGISTRAR'S SIGNATURE J. Davidson-Randall			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33590

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) Dorothy Weinstein Lehman				2. DATE OF DEATH MONTH DAY YEAR Oct. 18 1994		3. TIME OF DEATH HOURS MIN. SEC. 9:00 a. M	
4. SOCIAL SECURITY NUMBER 577-48-3286		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct. 22 1910	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) 8100 Connecticut Ave. #1516		9b. CITY, TOWN OR LOCATION OF DEATH Bethesda	
9c. COUNTY OF DEATH Montgomery				10a. STATE Maryland		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION Bethesda				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 8100 Connecticut Ave. #1516	
10f. ZIP CODE 20815				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College				16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Home maker		16b. KIND OF BUSINESS/INDUSTRY Own home	
17. FATHER'S NAME (First, Middle, Last) Moses Rosenstein				16. MOTHER'S NAME (First, Middle, Maiden Surname) Bessie (unknown)			
19a. INFORMANT'S NAME (Type/Print) Howard Weinstein				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 904 Arbutus Rd. Annapolis, MD. 21403			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) King David Memorial Garden 10/20		20c. LOCATION — City or Town, State Falls Church, VA.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Danzansky-Goldberg Memorial Chapels 1170 Rockville Pike Rockville, MD. 20852			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Myocardial Infarct DUE TO (OR AS A CONSEQUENCE OF): b. Diffuse Arteriosclerosis DUE TO (OR AS A CONSEQUENCE OF): c. Diabetes Mellitis DUE TO (OR AS A CONSEQUENCE OF): d. Hypertension							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY HOURS MIN. SEC. M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD. FACP				29c. LICENSE NUMBER D13337		29d. DATE SIGNED (Month, Day, Year) 10/18/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) T. CHANDLER 224 Cunningham St. Berwyn Heights, Md							
31. DATE FILED (Month, Day, Year) OCT 19 1994				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33591

Amended #22, 10/24/94 MRF Montgomery City

1 -
FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Rosemary Lyne				2. DATE OF DEATH MONTH DAY YEAR October 20, 1994		3. TIME OF DEATH 2:00 P.M.	
4. SOCIAL SECURITY NUMBER 214-38-3130		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 76 YRS.	7. DATE OF BIRTH (Month, Day, Year) Aug. 31, 1918		8. BIRTHPLACE (State or Foreign Country) West Virginia	
9a. FACILITY NAME (If not institution, give street and number) Herman Wilson Health Care Center				9b. CITY, TOWN OR LOCATION OF DEATH Gaithersburg		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Gaithersburg		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 19439 Brassie Place #202				10f. ZIP CODE 20879		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Teacher		16b. KIND OF BUSINESS/INDUSTRY Secondary			
17. FATHER'S NAME (First, Middle, Last) Charles Franklin Lyne				18. MOTHER'S NAME (First, Middle, Maiden Surname) Rose Eleanor Snyder			
19a. INFORMANT'S NAME (Type/Print) Rachel Jorgensen				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19439 Brassie Place #202, Gaithersburg, MD 20879			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 10/21/94		20c. LOCATION — City or Town, State Alexandria, VA			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Michael D. Gilbey				22. NAME AND ADDRESS OF FACILITY DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF):				Approximate interval Between Onset and Death 1 year	
		b. Arteriosclerotic Heart Disease DUE TO (OR AS A CONSEQUENCE OF):				1 year	
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Peripheral arteriosclerosis, breast carcinoma							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER James R. Moore Jr		29c. LICENSE NUMBER 07231		29d. DATE SIGNED (Month, Day, Year) Oct 20, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) James R. Moore Jr 207 Brookes Ave Gaithersburg MD 20877							
31. DATE FILED (Month, Day, Year) OCT 24 1994		32. REGISTRAR'S SIGNATURE Julia Davidson-Pendell					

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

94 33592

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) Mary Katherine Löffler				2. DATE OF DEATH MONTH DAY YEAR October 20, 1994				3. TIME OF DEATH 9:30 P M					
4. SOCIAL SECURITY NUMBER 578-46-0067		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 83 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) April 17, 1911		8. BIRTHPLACE (State or Foreign Country) Washington, D.C.			
9a. FACILITY NAME (If not institution, give street and number) Chesapeake Manor Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Arnold				9c. COUNTY OF DEATH Anne Arundel					
RESIDENCE OF DECEASED													
10a. STATE Maryland		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Pasadena				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
10e. STREET AND NUMBER 8649 Black Rock Harbour				10f. ZIP CODE 21122				10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yea or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE - American Indian, Black, White, etc. Specify: White					
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker				16b. KIND OF BUSINESS/INDUSTRY					
17. FATHER'S NAME (First, Middle, Last) Claude Koontz						18. MOTHER'S NAME (First, Middle, Maiden Surname) Marie Faherty							
19a. INFORMANT'S NAME (Type/Print) Mary Lain Murphy				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8649 Black Rock Harbour Pasadena, Maryland 21122									
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Rock Creek Cemetery 10/24/94				20c. LOCATION - City or Town, State Washington, D.C.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Andrew J. Cole				22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute Cerebral Vascular Accident a. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.										Approximate interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Old Cerebral Vascular Accident										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER Cityman M. Attending Doctor				29c. LICENSE NUMBER D21684				29d. DATE SIGNED (Month, Day, Year) 10-21-94					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) C.V. CYRIAC, M.D., 1600 CRAWFORD, GLENBURNIE, MD 21061.													
31. DATE FILED (Month, Day, Year) OCT 24 1994				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33593

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Shun CHUN LAI</u>				2. DATE OF DEATH MONTH <u>Oct</u> DAY <u>20</u> YEAR <u>94</u>		3. TIME OF DEATH <u>5:55 A.M.</u>	
4. SOCIAL SECURITY NUMBER <u>579-02-0319</u>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>52</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>Nov. 21, 1941</u>	
8. BIRTHPLACE (State or Foreign Country) <u>China</u>				9a. FACILITY NAME (If not institution, give street and number) <u>Suburban Hospital</u>		9b. CITY, TOWN OR LOCATION OF DEATH <u>Bethesda</u>	
9c. COUNTY OF DEATH <u>Montgomery</u>				10a. STATE <u>Maryland</u>		10b. COUNTY <u>Montgomery</u>	
10c. CITY, TOWN OR LOCATION <u>Olney</u>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <u>17116 Thortondale Court</u>	
10f. ZIP CODE <u>20832</u>				10g. CITIZEN OF WHAT COUNTRY? <u>United States</u> Permanent Resident		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>Chinese</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u></u>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Chef</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Restaurant</u>	
17. FATHER'S NAME (First, Middle, Last) <u>Ting-Hai Lai</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Kwai Leung</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Kahing Lai</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>17116 Thortondale Court, Olney, Maryland 20832</u>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>George Washington Cemetery</u> <u>10/25</u>		20c. LOCATION — City or Town, State <u>Adelphi, Maryland</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Andrew T. Further</u>				22. NAME AND ADDRESS OF FACILITY <u>Hines-Rinaldi Funeral Home, Inc.</u> <u>11800 New Hampshire Ave., Silver Spring, MD</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>MALIGNANT MYELOFIBROSIS</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>GASTROINTESTINAL BLEEDING</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u></u> DUE TO (OR AS A CONSEQUENCE OF): d. <u></u> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>THROMBOCYTOPENIA</u>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Alpana Goswami MD.</u>				29c. LICENSE NUMBER <u>D-27660</u>		29d. DATE SIGNED (Month, Day, Year) <u>10/23/94</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>ALPANA GOSWAMI, 8401 COLESVILLE ROAD, SILVER SPRING</u>							
31. DATE FILED (Month, Day, Year) <u>OCT 25 1994</u>				32. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33594

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Ialene June Lyons				2. DATE OF DEATH MONTH DAY YEAR October 29, 1994				3. TIME OF DEATH 1150 A M	
4. SOCIAL SECURITY NUMBER 218 22 7547		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 66 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 14, 1928		8. BIRTHPLACE (State or Foreign Country) Pennsylvania	
9a. FACILITY NAME (If not institution, give street and number) 44 Creston Lane				9b. CITY, TOWN OR LOCATION OF DEATH Solomons				9c. COUNTY OF DEATH Calvert	
10a. STATE Maryland		10b. COUNTY Calvert		10c. CITY, TOWN OR LOCATION Solomons				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 44 Creston Lane				10f. ZIP CODE 20688		10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY home			
17. FATHER'S NAME (First, Middle, Last) John Nitterright				18. MOTHER'S NAME (First, Middle, Maiden Surname) Agnes Mathias					
19a. INFORMANT'S NAME (Type/Print) Walter T. Lyons				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 44 Creston Lane Solomons, Maryland 20688					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Maryland Veterans Cemetery		DATE 11/1/94		20c. LOCATION — City or Town, State Cheltenham P.G. Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>B. Rausch</i>				22. NAME AND ADDRESS OF FACILITY Rausch Funeral Home P.A. 4405 Broomes Is. Rd. Port Republic Md 20676					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Small Cell Lung Cancer DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):								Approximate Interval Between Onset and Death 22 months	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Peptic Ulcer Disease / Chronic Gastritis Chronic Bronchitis								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER Placida L. L. M.D.					
29c. LICENSE NUMBER D41794				29d. DATE SIGNED (Month, Day, Year) 10-31-94					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)									
31. DATE FILED (Month, Day, Year) OCT 31 1994				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



RECEIVED JUL 16 1964

U.S. DEPARTMENT OF AGRICULTURE


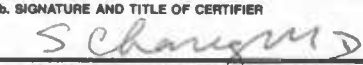

WASHINGTON, D.C.

APR 16 1964

94 33595

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ELMER E. LEWIS				2. DATE OF DEATH MONTH DAY YEAR October 27 1994		3. TIME OF DEATH 4:40 A M	
4. SOCIAL SECURITY NUMBER 217-10-7025		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		5. AGE (In yrs. last birthday) 82 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 15 1912	
9a. FACILITY NAME (If not institution, give street and number) Frostburg Hospital, Inc.				9b. CITY, TOWN OR LOCATION OF DEATH Frostburg		9c. COUNTY OF DEATH Allegany	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Allegany		10c. CITY, TOWN OR LOCATION Frostburg		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 19346 Lower Consol Road N.W.				10f. ZIP CODE 21532		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W.W.II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 6+) W.W.II		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Laborer/Driver		16b. KIND OF BUSINESS/INDUSTRY Textiles			
17. FATHER'S NAME (First, Middle, Last) Benjamin Lewis				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Catherine Orndorff			
19a. INFORMANT'S NAME (Type/Print) Geraldine Lewis				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19346 Lower Consol Rd. Frostburg, Md. 21532			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Rocky Gap Veterans Cemetery 10/31/94		20c. LOCATION — City or Town, State Flintstone, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Durst Funeral Home 57 Frost Avenue Frostburg, Maryland 21532			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ACUTE MYOCARDIAL INFARCTION DUE TO (OR AS A CONSEQUENCE OF): CORONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): CONGESTIVE HEART FAILURE DIABETES MELLITUS							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CONGESTIVE HEART FAILURE DIABETES MELLITUS							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D 25638		29d. DATE SIGNED (Month, Day, Year) 10/28/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Saturnina T. Chang Frostburg Plaza, Frostburg, Md. 21532							
31. DATE FILED (Month, Day, Year) OCT 31 1994		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit form.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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94 33596

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Robert Eugene Liller				2. DATE OF DEATH MONTH DAY YEAR 10-18-1994		3. TIME OF DEATH 2:30 A. M	
4. SOCIAL SECURITY NUMBER 578-42-4792		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 62 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10-7-1932	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Residence-11711 Fingerboard Rd.		9b. CITY, TOWN OR LOCATION OF DEATH Monrovia	
9c. COUNTY OF DEATH Frederick				10a. STATE Maryland		10b. COUNTY Frederick	
10c. CITY, TOWN OR LOCATION Monrovia				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 11711 Fingerboard Rd.	
10f. ZIP CODE 21770				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: White				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 6			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Electrician				16b. KIND OF BUSINESS/INDUSTRY Electrical			
17. FATHER'S NAME (First, Middle, Last) Herbert D. Liller				18. MOTHER'S NAME (First, Middle, Maiden Surname) Pauline Shreve			
19a. INFORMANT'S NAME (Type/Print) Joyce Ann Haveland				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 201 Advance Ct. Frederick, Md. 21701			
20a. MANNER OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Resthaven Crematory 10-18-94			
20c. LOCATION — City or Town, State Frederick, Maryland				21. SIGNATURE OF FUNERAL SERVICE LICENSEE E. A. W. L. P.			
22. NAME AND ADDRESS OF FACILITY Cumberland, Md. 21502 Leasure-Stein, Inc. 230 Baltimore Ave				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Cancer of the Floor of the mouth</u> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER C. L. Marshall			
29c. LICENSE NUMBER 0-18191				29d. DATE SIGNED (Month, Day, Year) 10-21-94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Arthur G. Marshall, M.D. 187 Thomas Johnson B. Frederick MD 21702							
31. DATE FILED (Month, Day, Year) OCT 27 1994				32. REGISTRAR'S SIGNATURE C. L. Marshall-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,


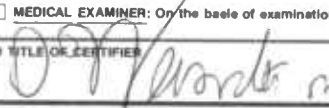
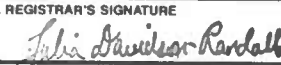
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33597

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) VICTOR F. LEWIS				2. DATE OF DEATH MONTH 10 DAY 31 YEAR 94		3. TIME OF DEATH 2335 M	
4. SOCIAL SECURITY NUMBER 213-14-4535		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 7, 1922	
8. FACILITY NAME (If not institution, give street and number) Anne Arundel Medical Center				9. CITY, TOWN OR LOCATION OF DEATH Annapolis		10. COUNTY OF DEATH Anne Arundel	
11. RESIDENCE OF DECEDENT 10a. STATE Maryland 10b. COUNTY Anne Arundel 10c. CITY, TOWN OR LOCATION Annapolis 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				12. STREET AND NUMBER 3 Chester Ave.			
13. ZIP CODE 21403				14. CITIZEN OF WHAT COUNTRY? United States			
15. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		16. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W.W. II		17. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		18. RACE — American Indian, Black, White, etc. Specify: Caucasian	
19. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) _____		20. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Sheet Metal		21. KIND OF BUSINESS/INDUSTRY Civil Service			
22. FATHER'S NAME (First, Middle, Last) Harry E. Lewis				23. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Anne Brown			
24. INFORMANT'S NAME (Type/Print) Audrey C. Lewis (wife)				25. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Chester Ave. Annapolis, Md. 21403			
26. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) _____		27. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Ft. Lincoln Crematory 11-2-94		28. LOCATION — City or Town, State Brentwood, Md.			
29. SIGNATURE OF FUNERAL SERVICE LICENSEE 				30. NAME AND ADDRESS OF FACILITY John M. Taylor Funeral Home 147 Duke of Gloucester Annapolis, Md. 21401			
31. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Coronary Artery Disease Due to (or as a consequence of): Cigarette Smoking SEQUENTIALLY LIST CONDITIONS, IF ANY, LEADING TO IMMEDIATE CAUSE. ENTER UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST Sepsis, Prosthetic Coroner							
32. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Sepsis, Prosthetic Coroner							
33. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		34. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) _____					
35. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		36. DATE OF INJURY (Month, Day, Year)		37. TIME OF INJURY M 1 YES 2 NO		38. DESCRIBE HOW INJURY OCCURRED	
39. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		40. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
41. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
42. SIGNATURE AND TITLE OF CERTIFIER 				43. LICENSE NUMBER D 38445		44. DATE SIGNED (Month, Day, Year) Nov. 1, 1994	
45. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ira M. Weinstein, M.D. 600 Ridgley Ave. #121 Annapolis, Md. 21401 (410-266-1644)							
46. DATE FILED (Month, Day, Year) NOV 03 1994		47. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician after death. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial certificate. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33598

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARY ELIZABETH McMILLEN				2. DATE OF DEATH MONTH DAY YEAR OCTOBER 24, 1994		3. TIME OF DEATH 7:41 A M	
4. SOCIAL SECURITY NUMBER 234-26-1690		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) SEPT 18, 1917	
9a. FACILITY NAME (If not institution, give street and number) GARRETT CO. MEMORIAL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH OAKLAND		9c. COUNTY OF DEATH GARRETT	
RESIDENCE OF DECEDENT							
10a. STATE W. VA.		10b. COUNTY PRESTON		10c. CITY, TOWN OR LOCATION ROWLESBURG		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER SPRING STREET (P.O. BOX 35)				10f. ZIP CODE 26425		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER		16b. KIND OF BUSINESS/INDUSTRY OWN HOME			
17. FATHER'S NAME (First, Middle, Last) HAROLD STANLEY MYERS				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARGARET BECKER			
19a. INFORMANT'S NAME (Type/Print) THOMAS F. McMILLEN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 35 ROWLESBURG, W. VA. 26425			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) AURORA CEMETERY		DATE 10/27		20c. LOCATION — City or Town, State AURORA, W. VA.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert H. Durst</i> M00167				22. NAME AND ADDRESS OF FACILITY P.O. BOX 243 DURST FUNERAL HOME - OAKLAND, MD. 21550			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Ovarian carcinoma</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Robert H. Durst</i>				29c. LICENSE NUMBER D39811		29d. DATE SIGNED (Month, Day, Year) 10/25/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JERRY ADAMS, M.D. 311 N. 4TH STREET OAKLAND, MD 21550							
31. DATE FILED (Month, Day, Year) OCT 25 1994		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33599

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) FLOYD HENRY MAYLE			2. DATE OF DEATH MONTH OCTOBER DAY 17 YEAR 1994		3. TIME OF DEATH 06:54 A M		
4. SOCIAL SECURITY NUMBER 220 16 7052		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 67 YRS.		7. DATE OF BIRTH (Month, Day, Year) 6-26-1927	
9a. FACILITY NAME (If not institution, give street and number) SACRED HEART HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND			9c. COUNTY OF DEATH ALLEGANY	
10a. STATE Md		10b. COUNTY Garrett		10c. CITY, TOWN OR LOCATION Swanton		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER PO Box 3014			10f. ZIP CODE 21561		10g. CITIZEN OF WHAT COUNTRY? USA		
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW!!		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Gen. Motors		16b. KIND OF BUSINESS/INDUSTRY Auto.			
17. FATHER'S NAME (First, Middle, Last) Henry G. Mayle				18. MOTHER'S NAME (First, Middle, Maiden Surname) Beulah Moore			
19a. INFORMANT'S NAME (Type/Print) Twila Cooper				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt3 Oakland, Md 21550			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Deer Park Cemetery		20c. LOCATION — City or Town, State 10+19-94 Deer Park Md			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>David A. Burdock</i>				22. NAME AND ADDRESS OF FACILITY David A. Burdock FH PO Box 523 Kitzmiller, Md 21538			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → metastatic lung cancer DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. acute renal failure						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Robert Orfino, M.D.</i>				29c. LICENSE NUMBER D34846		29d. DATE SIGNED (Month, Day, Year) 10/18/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. ROBERT ORLINO, M.D., 902 SETON DRIVE, CUMBERLAND, MD 21502							
31. DATE FILED (Month, Day, Year) OCT 20 1994				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial certificate. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33600

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mary Alberta Mann				2. DATE OF DEATH MONTH DAY YEAR November 6, 1994		3. TIME OF DEATH 6:25 A.M.	
4. SOCIAL SECURITY NUMBER 214-28-5104		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) OCT. 22, 1909	
9a. FACILITY NAME (If not institution, give street and number) Reeders Memorial Home				9b. CITY, TOWN OR LOCATION OF DEATH BOONSBORO		9c. COUNTY OF DEATH WASHINGTON	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY WASHINGTON		10c. CITY, TOWN OR LOCATION BOONSBORO		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 27 POTOMAC STREET				10f. ZIP CODE 21713		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER		16b. KIND OF BUSINESS/INDUSTRY OWN HOME	
17. FATHER'S NAME (First, Middle, Last) RALPH McLYN FRY				16. MOTHER'S NAME (First, Middle, Maiden Surname) ALICE ELIZABETH RITCHIE			
19a. INFORMANT'S NAME (Type/Print) ROY S. MANN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8049 MAPLEVILLE ROAD, BOONSBORO, MARYLAND 21713			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BOONSBORO CEMETERY 11/9/94		20c. LOCATION — City or Town, State BOONSBORO, MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Paul M. Dean Paul M. Dean				22. NAME AND ADDRESS OF FACILITY BAST FUNERAL HOME 7606 Old National Pike Boonsboro, MD 21713			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Exacerbation of chronic obstructive lung disease 1 day					
		b. Respiratory Failure probably in consequence of 30 min					
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		c. Congestive heart failure					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]				29c. LICENSE NUMBER 344996		29d. DATE SIGNED (Month, Day, Year) 11-7-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Zafar Malik 20311 Lappans Road Boonsboro, Maryland 21713							
31. DATE FILED (Month, Day, Year) NOV 07 1994		32. REGISTRAR'S SIGNATURE [Signature]					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33601

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ROSALIE JEANETTE MITCHELL				2. DATE OF DEATH MONTH DAY YEAR 10 31 94		3. TIME OF DEATH 0910 M	
4. SOCIAL SECURITY NUMBER 217-09-9801		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 80 YRS.		7. DATE OF BIRTH (Month, Day, Year) August 24, 1914	
9a. FACILITY NAME (If not institution, give street and number) Washington County Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown		9c. COUNTY OF DEATH Washington	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Hagerstown		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 9946 Downsville Pike				10f. ZIP CODE 21740		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Seamstress		16b. KIND OF BUSINESS/INDUSTRY Hosiery			
17. FATHER'S NAME (First, Middle, Last) Earl Theodore Zimmerman				18. MOTHER'S NAME (First, Middle, Maiden Surname) Grace Elizabeth Garrish			
19a. INFORMANT'S NAME (Type/Print) Nancy Kees				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11346 Lakeside Dr. Hagerstown, MD 21740			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of facility, cemetery or other place) Greentown Mem. Park Nov. 3, 1994		20c. LOCATION — City or Town, State Williamsport, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶		22. NAME AND ADDRESS OF FACILITY Osborne Funeral Home 21795 425 S. Conococheague St. Williamsport, MD					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
a. <i>death pulmonary edema</i> DUE TO (OR AS A CONSEQUENCE OF):							3 hours
b. <i>congestive heart failure</i> DUE TO (OR AS A CONSEQUENCE OF):							2 weeks
c. <i>arteriosclerotic heart disease</i> DUE TO (OR AS A CONSEQUENCE OF):							years
d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Left right kidneys caused the infection & sepsis and all pneumonia; Crohn's disease & renal failure</i>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Edward Hood Jr.</i>				29c. LICENSE NUMBER D07857		29d. DATE SIGNED (Month, Day, Year) ▶ 11/12/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr E Moody 1190 Mt Aetna Road Hagerstown MD 21740							
31. DATE FILED (Month, Day, Year) NOV 03 1994		32. REGISTRAR'S SIGNATURE <i>Julius Benson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33602

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Leah M. Martin</i>				2. DATE OF DEATH MONTH <i>11</i> DAY <i>1</i> YEAR <i>94</i>		3. TIME OF DEATH <i>9:40 a.m.</i>	
4. SOCIAL SECURITY NUMBER <i>216-84-9061</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>101</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>10 24 1893</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i>		9a. FACILITY NAME (If not institution, give street and number) <i>19815 Reidtown Road</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Hagerstown</i>		9c. COUNTY OF DEATH <i>Washington</i>	
10a. STATE <i>MD.</i>		10b. COUNTY <i>Washington</i>		10c. CITY, TOWN OR LOCATION <i>Hagerstown</i>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>19815 Reidtown Road</i>		10f. ZIP CODE <i>21740</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>8</i> College (1-4 or 5+) <i></i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Home</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Henry Baer</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Barbara Martin</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Grant B. Martin</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2816 State Line Road Waynesboro, Pa. 17268</i>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Mennonite Church Cemetery 11/4/94</i>		20c. LOCATION — City or Town, State <i>Washington Co. Md.</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>H. Martin Zimmerman</i>				22. NAME AND ADDRESS OF FACILITY <i>Zimmerman And Son Funeral Home Greencastle, Pa.</i>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>CEREBROVASCULAR ACCIDENT</i> Approximate interval Between Onset and Death <i>6 days</i> Sequitely that conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Robert Bruhl MD Personal Physician</i>				29c. LICENSE NUMBER <i>D04359</i>		29d. DATE SIGNED (Month, Day, Year) <i>11/1/94</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Robert Bruhl MD 1459 Potomac Ave Hagerstown MD 21742</i>							
31. DATE FILED (Month, Day, Year) <i>NOV 03 1994</i>				32. REGISTRAR'S SIGNATURE <i>John Benson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33603

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Vernon G. Moning				2. DATE OF DEATH MONTH November DAY 2 YEAR 1994				3. TIME OF DEATH 1237P M	
4. SOCIAL SECURITY NUMBER 217-56-0313		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 44 YRS.		7. DATE OF BIRTH (Month, Day, Year) DEC. 6, 1949		8. BIRTHPLACE (State or Foreign Country) MARYLAND	
9a. FACILITY NAME (If not Institution, give street and number) WASHINGTON COUNTY HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH HAGERSTOWN				9c. COUNTY OF DEATH WASHINGTON	
10a. STATE MARYLAND		10b. COUNTY WASHINGTON		10c. CITY, TOWN OR LOCATION HAGERSTOWN				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1310 POTOMAC AVENUE				10f. ZIP CODE 21742				10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 YEARS College (1-4 or 5+) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SYSTEMS OPERATOR				16b. KIND OF BUSINESS/INDUSTRY SECURITY SYSTEMS	
17. FATHER'S NAME (First, Middle, Last) HENRY ALBERT MONING				18. MOTHER'S NAME (First, Middle, Maiden Surname) LAURA ELEANOR CARLSON					
19a. INFORMANT'S NAME (Type/Print) H. CLARKE MONING				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13407 KEENER ROAD, HAGERSTOWN, MARYLAND 21742					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) REST HAVEN CEMETERY NOV. 5, 1994				20c. LOCATION — City or Town, State HAGERSTOWN, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE DOUGLAS A. FIERY				22. NAME AND ADDRESS OF FACILITY DOUGLAS A. FIERY FUNERAL HOME 21742 1331 EASTERN B'VD. NORTH, HAGERSTOWN, MD					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Ventricular fibrillation Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):				Approximate interval Between Onset and Death					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Cerebral palsy				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER Samuel Chaw				29c. LICENSE NUMBER D36655	
29b. SIGNATURE AND TITLE OF CERTIFIER Samuel Chaw				29c. LICENSE NUMBER D36655				29d. DATE SIGNED (Month, Day, Year) 11/3/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 1111 MT BETNA RD.				31. DATE FILED (Month, Day, Year) NOV 04 1994					
31. DATE FILED (Month, Day, Year) NOV 04 1994				32. REGISTRAR'S SIGNATURE Hag. Md 21740					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Please be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33604

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ARTHUR JAMES MOHN				2. DATE OF DEATH MONTH 11 DAY 3 YEAR 94		3. TIME OF DEATH 4:30 P M	
4. SOCIAL SECURITY NUMBER 173-03-3567		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 84 YRS.		7. DATE OF BIRTH (Month, Day, Year) 3/25/1910	
9a. FACILITY NAME (If not institution, give street and number) WASHINGTON COUNTY HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH HAGERSTOWN		9c. COUNTY OF DEATH WASHINGTON	
10a. STATE MD				10b. COUNTY WASHINGTON		10c. CITY, TOWN OR LOCATION HAGERSTOWN	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 21307 LEITERSBURG PIKE			
10f. ZIP CODE 21742				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+)		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) PAINTER		17. KIND OF BUSINESS/INDUSTRY LUMBER COMPANY			
17. FATHER'S NAME (First, Middle, Last) SOLOMON MOHN				18. MOTHER'S NAME (First, Middle, Maiden Surname) ELSIE PATTERSON			
19a. INFORMANT'S NAME (Type/Print) EDITH M. MOHN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21307 LEITERSBURG PIKE, HAGERSTOWN, MD 21742			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) LEITERSBURG LUTHERAN CEM DATE 7		20c. LOCATION — City or Town, State LEITERSBURG, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James E. Bowersox</i> JAMES A. BOWERSOX		22. NAME AND ADDRESS OF FACILITY GROVE FUNERAL HOME, INC. 50 S BROAD ST, WAYNESBORO, PA 17268					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → acute myocardial infarction							
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
<div style="display: flex; justify-content: space-between;"> <div> Coronary artery disease DUE TO (OR AS A CONSEQUENCE OF): Atherosclerosis DUE TO (OR AS A CONSEQUENCE OF): </div> <div> Approximate interval Between Onset and Death 3 hours years years </div> </div>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypoxic Encephalopathy Diabetes							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>W S Hood MD</i>		29c. LICENSE NUMBER D 21400		29d. DATE SIGNED (Month, Day, Year) 11-3-94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) W. S. Hood, M.D., 249 Mill St, Hagerstown, Md 21740							
31. DATE FILED (Month, Day, Year) NOV 07 1994		32. REGISTRAR'S SIGNATURE <i>John S. Anderson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33605

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Lola Catherine Leiboldt</i>				2. DATE OF DEATH MONTH DAY YEAR <i>November 4, 1994</i>		3. TIME OF DEATH M <i>1447</i>	
4. SOCIAL SECURITY NUMBER <i>220-28-7727</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>86</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Nov. 8, 1907</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Washington County Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Hagerstown</i>		9c. COUNTY OF DEATH <i>Washington</i>	
RESIDENCE OF DECEDENT							
10a. STATE <i>Md.</i>		10b. COUNTY <i>Washington</i>		10c. CITY, TOWN OR LOCATION <i>Smithsburg</i>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>9 Blue Mt. Estates</i>				10f. ZIP CODE <i>21783</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Home</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Dallas Walton Misner</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Rosie Catherine Green</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Patricia Kline</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>23421 Leather Rd. Smithsburg, Md. 21783</i>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Mt. Bethel Cemetery 11-7-94</i>		20c. LOCATION — City or Town, State <i>Foxville, Md.</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dennis L. Davis</i>				22. NAME AND ADDRESS OF FACILITY <i>Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783</i>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Pulmonary Edema</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Acute Myocardial Infarction</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Arterio-sclerotic Cardiovascular Disease</i> DUE TO (OR AS A CONSEQUENCE OF):							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Renal Failure</i>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <i>1</i>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Vasant Datta MD</i>		29c. LICENSE NUMBER <i>D18019</i>		29d. DATE SIGNED (Month, Day, Year) <i>11.4.94</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>VASANT DATTA, MD 334 MILL ST HAGERSTOWN, MD 21740</i>							
31. DATE FILED (Month, Day, Year) <i>NOV 07 1994</i>		32. REGISTRAR'S SIGNATURE <i>John T. Harrison</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33606

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Harold William Mills				2. DATE OF DEATH MONTH DAY YEAR November 3 1994		3. TIME OF DEATH 1503 M	
4. SOCIAL SECURITY NUMBER 705-10-7147		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 84 YRS.	7. DATE OF BIRTH (Month, Day, Year) 10-12-1910		8. BIRTHPLACE (State or Foreign Country) MD.	
9a. FACILITY NAME (If not institution, give street and number) Washington County Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown,		9c. COUNTY OF DEATH Washington	
10a. STATE MD.		10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Big Pool,		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 12720 Pecktonville Road				10f. ZIP CODE 21711		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Assembly worker		16b. KIND OF BUSINESS/INDUSTRY Fairchild Industries			
17. FATHER'S NAME (First, Middle, Last) Victor Daniel Mills				18. MOTHER'S NAME (First, Middle, Maiden Surname) Rose Ellen Reed			
19a. INFORMANT'S NAME (Type/Print) Leona Mills				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12720 Pecktonville Rd. Big Pool, MD. 21711			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery or place of burial or other place) Parkhead Cem. 11-5-1994		20c. LOCATION — City or Town, State Big Pool, MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael M. Edwards</i>				22. NAME AND ADDRESS OF FACILITY Thompson Funeral Home, Inc. P.O. Box 310 Clear Spring, MD. 21722			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Hypertensive hemorrhagic heart disease</i> DUE TO (OR AS A CONSEQUENCE OF):					Approximate interval between Onset and Death 4 yrs
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED					
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>James A. ...</i>				29c. LICENSE NUMBER D07885		29d. DATE SIGNED (Month, Day, Year) 11-4-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr Hornbaker 354 Mill Street Hagerstown Md							
31. DATE FILED (Month, Day, Year) NOV 07 1994				32. REGISTRAR'S SIGNATURE <i>John Benson ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33607

Amended # 206 10/27/94 MRT Montgomery Cty

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Myron Samuel Malkin				2. DATE OF DEATH MONTH 10 DAY 24 YEAR 94		3. TIME OF DEATH 7:35 pm	
4. SOCIAL SECURITY NUMBER 287-16-7334		5. SEX 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 70 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 6, 1924	
9a. FACILITY NAME (If not institution, give street and number) Suburban Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Bethesda		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Bethesda		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 7004 Orkney Parkway				10f. ZIP CODE 20817		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1943-1946		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5+		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Aerospace Executive		16b. KIND OF BUSINESS/INDUSTRY Aerospace			
17. FATHER'S NAME (First, Middle, Last) Morris Malkin				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah Magidson			
19a. INFORMANT'S NAME (Type/Print) Jocelyn S. Malkin				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7004 Orkney Parkway, Bethesda, Maryland 20817			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc.		20c. LOCATION — City or Town, State Bethesda, Maryland		20d. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael E. Hegin</i> M00846				22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Anoxic encephalopathy DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		b. cardiac arrest DUE TO (OR AS A CONSEQUENCE OF):					
		c. cardiac arrhythmia DUE TO (OR AS A CONSEQUENCE OF):					
		d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Harry Bigham M.D.</i>				29c. LICENSE NUMBER 138888		29d. DATE SIGNED (Month/Day/Year) 10/25/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Harry Bigham, MD 610 Rockledge Drive Bethesda MD 20817							
31. DATE FILED (Month, Day, Year) OCT 27 1994				32. REGISTRAR'S SIGNATURE <i>Jake Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

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moore. Carl V.

94 33608

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Carl V. Moore, Sr.				2. DATE OF DEATH MONTH DAY YEAR Oct. 26, 1994		3. TIME OF DEATH 2:00 p. M	
4. SOCIAL SECURITY NUMBER 717-09-5725		5. SEX XX M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 16, 1917	
9a. FACILITY NAME (If not institution, give street and number) Laurel Regional Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Laurel		9c. COUNTY OF DEATH Prince George's	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Beltsville		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 4213 Howard Road				10f. ZIP CODE 20705		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married XX Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? XX YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1940 - 1945		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES XX NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years College (1-4 or 5+) 4yrs. +2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Accountant		16b. KIND OF BUSINESS/INDUSTRY U.S. Government			
17. FATHER'S NAME (First, Middle, Last) Joseph Carl Moore				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ella C. Kyler			
19a. INFORMANT'S NAME (Type/Print) Beula K. Moore				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as #10			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 8 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Riverview Cemetery 10/29/1994		DATE 10/29/1994		20c. LOCATION — City or Town, State Huntingdon, Pennsylvania	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Donald V. Borgwardt				22. NAME AND ADDRESS OF FACILITY Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Md. 20705			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		Respiratory Failure.				Approximate interval Between Onset and Death 12 hrs	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		a. DUE TO (OR AS A CONSEQUENCE OF): Cerebral Hemorrhage.				29 hrs	
		b. DUE TO (OR AS A CONSEQUENCE OF): Hypertension.				many years.	
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Obstructive Pulmonary Disease. Myasthenia Gravis							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Lawrence R. Whicker MD				29c. LICENSE NUMBER D37979		29d. DATE SIGNED (Month, Day, Year) 10/26/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Lawrence R. Whicker MD 7500 Loma Park #201, Greenbelt MD 20770							
31. DATE FILED (Month, Day, Year) OCT 28 1994				32. REGISTRAR'S SIGNATURE Julia Davidson-Randell			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 through 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33609

Amended #1, 10/28/94, J.W., Montgomery Co.

1 - STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MAURICE MONTANO		2. DATE OF DEATH MONTH 10 DAY 26 YEAR 94		3. TIME OF DEATH 1030 P.M.
4. SOCIAL SECURITY NUMBER 578-32-1671	5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 94 YRS.	7. DATE OF BIRTH (Month, Day, Year) 1900 September 22, Philippines	8. BIRTHPLACE (State or Foreign Country)
9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 103 Bluff Terrace		
10f. ZIP CODE 20902		10g. CITIZEN OF WHAT COUNTRY? U.S.A.		
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: Asian
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 3 College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Supervisor		16b. KIND OF BUSINESS/INDUSTRY Federal Government
17. FATHER'S NAME (First, Middle, Last) Unknown		18. MOTHER'S NAME (First, Middle, Maiden Surname) Unknown		
19a. INFORMANT'S NAME (Type/Print) Donald A. Montano		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 103 Bluff Terrace Silver Spring, Maryland 20902		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Cemetery 10/29/94 Brentwood, Maryland		20c. LOCATION — City or Town, State
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Andrew J. Cole		22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → PNEUMONIA Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST Respiratory Failure				Approximate Interval Between Onset and Death > 1 WEEK
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. SIGNATURE AND TITLE OF CERTIFIER John Davidson-Randall		29c. LICENSE NUMBER D43496		29d. DATE SIGNED (Month, Day, Year) 10-27-94
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MOHAMMAD A KHALID MD 1299-Lambert Drive Silver Spring 20902				
31. DATE FILED (Month, Day, Year) OCT 28 1994		32. REGISTRAR'S SIGNATURE John Davidson-Randall		

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33610

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ROBERT AARON MILLER				2. DATE OF DEATH MONTH DAY YEAR October 24, 1994		3. TIME OF DEATH 12:48 A M	
4. SOCIAL SECURITY NUMBER 579-05-0286		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 89 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 9, 1905	
9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland				10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 13004 Wilton Oaks Drive			
10f. ZIP CODE 20906				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Electrician		16b. KIND OF BUSINESS/INDUSTRY Electrical			
17. FATHER'S NAME (First, Middle, Last) Laban Miller				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ollie Whisnant			
19a. INFORMANT'S NAME (Type/Print) Ollie M. Sessions				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 515 Villa Avenue Front Royal, Virginia 22630			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parklawn Cemetery 10/27/94		20c. LOCATION — City or Town, State Rockville, Maryland		22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Andrew J. Cole</i>				22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901			
23. PART I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Aspiration Pneumonia DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PARKINSONISM DUE TO (OR AS A CONSEQUENCE OF): PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>R.T. Benack</i>				29c. LICENSE NUMBER D557		29d. DATE SIGNED (Month, Day, Year) 10/26/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) R.T. Benack MD 4115 Colie DR. Wheaton, MD 20906							
31. DATE FILED (Month, Day, Year) OCT 28 1994				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33611

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MYRA MENDELSON				2. DATE OF DEATH MONTH 10 DAY 16 YEAR 94		3. TIME OF DEATH 8:45 AM	
4. SOCIAL SECURITY NUMBER 578-52-4068		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 65 YRS.		7. DATE OF BIRTH (Month, Day, Year) SEPT. 7, 1929	
8. PLACE OF BIRTH MARYLAND							
9a. FACILITY NAME (If not institution, give street and number) 606 OCEAN PARKWAY				9b. CITY, TOWN OR LOCATION OF DEATH BERLIN		9c. COUNTY OF DEATH WORCESTER	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY WORCESTER		10c. CITY, TOWN OR LOCATION BERLIN		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 606 OCEAN PARKWAY, P.O. BOX 4623-OCEAN PINES				10f. ZIP CODE 21811		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER		16b. KIND OF BUSINESS/INDUSTRY OWN HOME			
17. FATHER'S NAME (First, Middle, Last) LOU SCHAFER				18. MOTHER'S NAME (First, Middle, Maiden Surname) ROSE BOXER			
19a. INFORMANT'S NAME (Type/Print) ALFRED MENDELSON				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 606 OCEAN PKWY. P.O. BOX 4623 - BERLIN, MARYLAND 21811			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) KING DAVID MEMORIAL GARDEN		DATE 10/18		20c. LOCATION — City or Town, State FALLS CHURCH, VIRGINIA	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert Thomas</i>				22. NAME AND ADDRESS OF FACILITY DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE-ROCKVILLE, MD. 20852			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. PANCREATIC CANCER DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death 11 months
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER D. J. ANTEZANA RESIDENT SURGEON				29c. LICENSE NUMBER MS166		29d. DATE SIGNED (Month, Day, Year) 10/21/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOHNS HOPKINS HOSPITAL 600 N. WOLFE ST. BALTIMORE MD 21205							
31. DATE FILED (Month, Day, Year) OCT 27 1994		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Pandell</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.


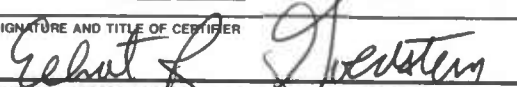

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Harry Willard Mullican				2. DATE OF DEATH MONTH DAY YEAR Oct. 20, 1994				3. TIME OF DEATH 7:35 P. M.					
4. SOCIAL SECURITY NUMBER 578-16-5212		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) May 11, 1910		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) Wilson Health Care Center						9b. CITY, TOWN OR LOCATION OF DEATH Gaithersburg,				9c. COUNTY OF DEATH Montgomery			
RESIDENCE OF DECEDENT													
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Gaithersburg						10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 9212 Edgewood Drive						10f. ZIP CODE 20877			10g. CITIZEN OF WHAT COUNTRY? United States				
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1944 - 1945				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Storekeeper				15b. KIND OF BUSINESS/INDUSTRY Self Employed					
17. FATHER'S NAME (First, Middle, Last) Henry Wooten Mullican						18. MOTHER'S NAME (First, Middle, Maiden Surname) Alice Victoria Ward							
19a. INFORMANT'S NAME (Type/Print) Paula Fay Dean				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1550 Northeast Ocean Blvd., Stuart, Florida 34996									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Forest Oak Cemetery 10/24				20c. LOCATION — City or Town, State Gaithersburg, MD.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY DeVol Funeral Home 10 E. Deer Park Dr., Gaithersburg, MD. 20877									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cerebrovascular Accident DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. Arteriosclerotic Vascular Disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.												Approximate interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Subdural Hematoma													
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER  Elliot R. Goldstein, M.D.						29c. LICENSE NUMBER D03518		29d. DATE SIGNED (Month, Day, Year) October 21, 1994					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Elliot R. Goldstein, M.D., 9410 Old Georgetown Road, Bethesda, Maryland 20814													
31. DATE FILED (Month, Day, Year) OCT 24 1994				32. REGISTRAR'S SIGNATURE 									

94 33613

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Peter Otto Murphy				2. DATE OF DEATH MONTH DAY YEAR Oct. 20, 1994		3. TIME OF DEATH 7:30 A.	
4. SOCIAL SECURITY NUMBER 343-38-5740		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 46 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 23, 1948	
9a. FACILITY NAME (If not institution, give street and number) 6703 Maple Avenue				9b. CITY, TOWN OR LOCATION OF DEATH Chevy Chase		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland				10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Chevy Chase	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 6703 Maple Avenue			
10f. ZIP CODE 20815				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) trade negotiator		16. KIND OF BUSINESS/INDUSTRY Executive Office of the President			
17. FATHER'S NAME (First, Middle, Last) William Thomas Murphy, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Martha Elaine Otto			
19a. INFORMANT'S NAME (Type/Print) Deirdre Maloney				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6703 Maple Ave., Chevy Chase, Md. 20815			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery Oct. 24, 94 Silver Spring, Md.		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John P. DeVol</i>		22. NAME AND ADDRESS OF FACILITY DeVol Funeral Home 2222 Wisconsin Ave., N.W., Wash., DC 20007					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. malignant glioblastoma DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death 2 years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Frederick P. Smith</i>				29c. LICENSE NUMBER D33293		29d. DATE SIGNED (Month, Day, Year) Oct. 20, 94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Frederick P. Smith, M.D., 5401 Western Ave., N.W., Washington, D.C. 20015							
31. DATE FILED (Month, Day, Year) OCT 25 1994				32. REGISTRAR'S SIGNATURE <i>John W. Harrison-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ITEMS: 23 PART I, 27, 28a,b,d,e,f, PER MEO FILM G-717 11/23/94 t.t

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) WILLIAM DALE MERCHANT				2. DATE OF DEATH MONTH: SEPT. DAY: 30, YEAR: 94		3. TIME OF DEATH 2:15 P M	
4. SOCIAL SECURITY NUMBER 612 54 6383		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 44 YRS.	7. DATE OF BIRTH (Month, Day, Year) Oct. 23, 1949	8. BIRTHPLACE (State or Foreign Country) Washington, DC		
9a. FACILITY NAME (If not institution, give street and number) 20400 FREDERICK RD.				9b. CITY, TOWN OR LOCATION OF DEATH GERMANTOWN		9c. COUNTY OF DEATH MONTGOMERY	
RESIDENCE OF DECEDENT							
10a. STATE MD.		10b. COUNTY MONTGOMERY		10c. CITY, TOWN OR LOCATION GERMANTOWN		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 20400 FREDERICK RD. LOT A14				10f. ZIP CODE 20876		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 10				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CARPENTER		16b. KIND OF BUSINESS/INDUSTRY SELF EMPLOYED	
17. FATHER'S NAME (First, Middle, Last) WILLIAM S. MERCHANT				18. MOTHER'S NAME (First, Middle, Maiden Surname) GERALDINE GABLE			
19a. INFORMANT'S NAME (Type/Print) GERALDINE MERCHANT				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2412 SIEBEL DRIVE, SILVER SPRING, MD. 20905			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) METROPOLITAN CREMATORY		DATE 10/4/94		20c. LOCATION — City or Town, State ALEXANDRIA, VA.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY TAKOMA FUNERAL HOME 254 CARROLL ST N.W. WASHINGTON, D.C. 20012			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. NARCOTIC INTOXICATION DUE TO (OR AS A CONSEQUENCE OF):							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) FOUND: 9-30-94		28b. TIME OF INJURY FOUND: 11:00 A		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED UNKNOWN				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) FOUND: ON FLOOR OF BATHROOM			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) AT HOME: 20400 FREDERICK RD. APT. 14 GERMANTOWN, MARYLAND							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) OCT 1, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARJORIE AKORRE MD 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) OCT 17 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ALBERT BOHNER

1884-1885

ALBERT BOHNER

1884-1885

ALBERT BOHNER
1884-1885

94 33615

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Nina Morris Marrs				2. DATE OF DEATH MONTH October DAY 22 , YEAR 1994		3. TIME OF DEATH 4:10 P M	
4. SOCIAL SECURITY NUMBER 276-36-2131		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 97 YRS.	7. DATE OF BIRTH (Month, Day, Year) 10-20-1898		8. BIRTHPLACE (State or Foreign Country) VA	
9a. FACILITY NAME (If not institution, give street and number) Crofton Nursing Center				9b. CITY, TOWN OR LOCATION OF DEATH Crofton		9c. COUNTY OF DEATH Anne Arundel	
10a. STATE MD		10b. COUNTY Calvert		10c. CITY, TOWN OR LOCATION Chesapeake Beach		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER P.O. Box 311				10f. ZIP CODE 20732		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Home			
17. FATHER'S NAME (First, Middle, Last) Joel K. Sproles				18. MOTHER'S NAME (First, Middle, Maiden Surname) Fanny Mae Fleener			
19a. INFORMANT'S NAME (Type/Print) Robert Marrs				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1024 N.E. 27th Street Belle Glade, FL 33430			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 10-27-94		20c. LOCATION — City or Town, State Alexandria, VA			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Rausch Funeral Home, PA Owings, MD 20736			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Competitive heart failure DUE TO (OR AS A CONSEQUENCE OF): a. Competitive heart failure b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia, Malnutrition							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 9 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD				29c. LICENSE NUMBER D 38958		29d. DATE SIGNED (Month, Day, Year) 10/26/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DALJEET SINGH SIDHU, 1413 ANNAPOLIS RD #106 ODENTON MD 21113							
31. DATE FILED (Month, Day, Year) OCT 28 1994		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 6 and 7 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

5

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94 33616

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) PAULINE MURRAY				2. DATE OF DEATH MONTH October DAY 15 YEAR 1994		3. TIME OF DEATH 500 P M	
4. SOCIAL SECURITY NUMBER 241-30-0760		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 20, 1994	
8. BIRTHPLACE (State or Foreign Country) North Carolina				9a. FACILITY NAME (If not institution, give street and number) SOUTHEAST MARYLAND HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH CLINTON	
9c. COUNTY OF DEATH PRINCE GEORGES				10a. STATE Washington, D.C.		10b. COUNTY	
10c. CITY, TOWN OR LOCATION				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 219 Upsher St., N.E.	
10f. ZIP CODE 20011				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: Black				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) College			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Domestic				16b. KIND OF BUSINESS/INDUSTRY private industry			
17. FATHER'S NAME (First, Middle, Last) Joseph Bush				18. MOTHER'S NAME (First, Middle, Maiden Surname) Cherry Webb			
19a. INFORMANT'S NAME (Type/Print) Josephine Ford				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1505 Woodbine St., Alexandria, Va., 22302			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DATE			
20c. LOCATION — City or Town, State				21. SIGNATURE OF FUNERAL SERVICE LICENSEE M. J. Jeffers #642			
22. NAME AND ADDRESS OF FACILITY Fraziers Funeral Home 389 Rhode Island Av., NW, Washington, D.C.				23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiac arrest Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Cardiac arrhythmia Cardiomyopathy Approximate Interval Between Onset and Death 3 months Hours years			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes mellitus				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)			
28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER Joel Seuchand				29c. LICENSE NUMBER D 29646			
29d. DATE SIGNED (Month, Day, Year) 10-15-94				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOEL SEUCHAND WALDORF MD. 20601			
31. DATE FILED (Month, Day, Year) 1 OCT 18 1994				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

AMENDED #17, & 19a, 10/28/94, CTW, P.O. COUNTY

94 33617

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) Frank W. Marquette				2. DATE OF DEATH MONTH DAY YEAR October 24, 1994		3. TIME OF DEATH 5:55 A. M	
4. SOCIAL SECURITY NUMBER 579-20-7462		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 69 YRS.		7. DATE OF BIRTH (Month, Day, Year) August 16, 1925	
9a. FACILITY NAME (If not institution, give street and number) 1801 Brewton Court				9b. CITY, TOWN OR LOCATION OF DEATH District Heights		9c. COUNTY OF DEATH Prince Georges	
10a. STATE Maryland		10b. COUNTY Prince Georges		10c. CITY, TOWN OR LOCATION District Heights		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1801 Brewton Court				10f. ZIP CODE 20747		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1943 to 1946		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (13-16) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Management		16b. KIND OF BUSINESS/INDUSTRY Telephone Company			
17. FATHER'S NAME (First, Middle, Last) John Wesley Marquette				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lillie Minder			
19a. INFORMANT'S NAME (Type/Print) Lee Marquette Marquette				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1801 Brewton Ct., District Heights, MD 20747			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Cemetery 10/27		20c. LOCATION — City or Town, State Brentwood, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Fort Lincoln Funeral Home, Inc. 3401 Bladensburg Rd., Brentwood, MD 20722			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Esophageal Cancer DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death 3 Years
PART II. Other significant conditions contributing to death but not resulting in the underlying causes given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D20352		29d. DATE SIGNED (Month, Day, Year) October 24, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Harvey I. Matzen, M.D., 8926 Woodyard Road, #201, Clinton, Maryland 20737-4218							
31. DATE FILED (Month, Day, Year) OCT 28 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33618

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Robert Lee McCraney				2. DATE OF DEATH MONTH DAY YEAR October 21, 1994				3. TIME OF DEATH 9:45 AM	
4. SOCIAL SECURITY NUMBER 266-48-9499		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 58 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Nov. 2, 1935	
8. BIRTHPLACE (State or Foreign Country) Florida				9a. FACILITY NAME (If not institution, give street and number) 9025 49th Place				9b. CITY, TOWN OR LOCATION OF DEATH College Park	
9c. COUNTY OF DEATH Prince George's				10a. STATE Maryland				10b. COUNTY Prince George's	
10c. CITY, TOWN OR LOCATION College Park				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER 9025 49th Place				10f. ZIP CODE 20740				10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Welder		16b. KIND OF BUSINESS/INDUSTRY Construction					
17. FATHER'S NAME (First, Middle, Last) Marion Leondia McCraney				18. MOTHER'S NAME (First, Middle, Maiden Surname) Clara Rebels					
19a. INFORMANT'S NAME (Type/Print) Cheryl Dean				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9025 49th Place, College Park, Md. 20740					
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 10/22/94				20c. LOCATION — City or Town, State Alexandria, Virginia			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE W.B. Gaisner				22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home 4739 Baltimore Avenue, Hyattsville, Md.					
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. arteriosclerotic cardiovascular disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I: Chronic obstructive pulmonary disease								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Rafael Valle, MD.				29c. LICENSE NUMBER 212879		29d. DATE SIGNED (Month, Day, Year) Oct 22, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ARFONSO VALLE, MD. 10701 TRAFFIC DR., LARGO, MD. 20772									
31. DATE FILED (Month, Day, Year) OCT 25 1994				32. REGISTRAR'S SIGNATURE Juha Davidson-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33619

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) CLARENCE H. MC GINN				2. DATE OF DEATH MONTH DAY YEAR October 21, 1994		3. TIME OF DEATH 4:30 A M	
4. SOCIAL SECURITY NUMBER 077-18-9097		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 6, 1922	
8. BIRTHPLACE (State or Foreign Country) Staten, New York				9a. FACILITY NAME (If not institution, give street and number) PRINCE GEORGES HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH CHEVERLY	
9c. COUNTY OF DEATH PRINCE GEORGES				10a. STATE Maryland		10b. COUNTY Prince Georges	
10c. CITY, TOWN OR LOCATION Lanham				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 9308 Van Buren Street	
10f. ZIP CODE 20706				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) 12 College (1-4 or 5+) 4				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Dock Worker		16b. KIND OF BUSINESS/INDUSTRY U.S. Post Office	
17. FATHER'S NAME (First, Middle, Last) Clarence H. Mc Ginn				18. MOTHER'S NAME (First, Middle, Maiden Surname) Agnes Ellen Taylor			
19a. INFORMANT'S NAME (Type/Print) Juanita F. Mc Ginn				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9308 Van Buren Street, Lanham, MD 20706			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Long Island National Cemetery 10/25/94		20c. LOCATION — City or Town, State Pine Lawn, New York	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Rendon/Hale Lanham Funeral Home 9013 Annapolis Road, Lanham, MD 20706			
23. PART I. Enter the disease(s), or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Metastatic Carcinoma unknown Primary</i> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <i>Renal Failure</i> c. <i>Carcinoma of the prostate</i> d. Approximate Interval Between Onset and Death Weeks 3 weeks 3 years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Coronary heart disease</i> <i>Hypercalcemia</i>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>David M. Goldman</i>				29c. LICENSE NUMBER D04374		29d. DATE SIGNED (Month, Day, Year) 10.24.94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DAVID M. GOLDMAN M.D. 7500 Hanover Pkwy Greenbelt MD							
31. DATE FILED (Month, Day, Year) OCT 25 1994				32. REGISTRAR'S SIGNATURE <i>Jake Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33620

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>James A. Manley</i>				2. DATE OF DEATH MONTH <i>October</i> DAY <i>23</i> YEAR <i>1994</i>				3. TIME OF DEATH <i>2:30 A</i> M	
4. SOCIAL SECURITY NUMBER <i>577-16-0061</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>77</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>July 12, 1917</i>		8. BIRTHPLACE (State or Foreign Country) <i>Wash., D.C.</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>PRINCE GEORGES HOSPITAL CENTER</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>CHEVERLY</i>				9c. COUNTY OF DEATH <i>PRINCE GEORGES</i>	
10a. STATE <i>NA</i>				10b. COUNTY <i>NA</i>		10c. CITY, TOWN OR LOCATION <i>Washington, D.C.</i>			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <i>3001 Bladensburg Road, N.E. #1014</i>		10f. ZIP CODE <i>20018</i>		10g. CITIZEN OF WHAT COUNTRY? <i>United States</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>Elementary/Secondary (0-12) 12</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Stock Clerk</i>				16b. KIND OF BUSINESS/INDUSTRY <i>Paper Company</i>	
17. FATHER'S NAME (First, Middle, Last) <i>CHARLES MANLEY</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>LENA Herbert</i>					
19a. INFORMANT'S NAME (Type/Print) <i>Elizabeth Manley (Wife)</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3001 Bladensburg Rd., N.E. #1014 Wash, D.C. 20018</i>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Harmony Memorial Park 10/29</i>				20c. LOCATION — City or Town, State <i>Landover, Maryland</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Alex S. Pope Jr.</i> M859				22. NAME AND ADDRESS OF FACILITY <i>ALEXANDER S. POPE FUNERAL HOMES 5538 Marlboro Pike, Forestville, Md. 20747</i>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Arteriosclerotic cardiovascular disease</i> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death <i>year</i>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29b. SIGNATURE AND TITLE OF CERTIFIER <i>Augusto P. Rodriguez MD</i>	
29c. LICENSE NUMBER <i>A 212 30</i>								29d. DATE SIGNED (Month, Day, Year) <i>October 24, 1994</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETES CAUSE OF DEATH (ITEM 27) (Type/print) <i>Augusto P. Rodriguez MD, 5039 Rayburn Ct. Sp. Md 20748</i>								31. DATE FILED (Month, Day, Year) <i>OCT 27 1994</i>	
32. REGISTRAR'S SIGNATURE <i>J. Davidson</i>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33621

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) NAOMI MINOR				2. DATE OF DEATH MONTH DAY YEAR OCTOBER 22, 1994		3. TIME OF DEATH 05:31 P M	
4. SOCIAL SECURITY NUMBER 578-36-8978		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 64 YRS.		7. DATE OF BIRTH (Month, Day, Year) FEB. 5, 1930	
9a. FACILITY NAME (If not institution, give street and number) THE JOHN HOPKINS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH BALTIMORE	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY PRINCE GEORGES		10c. CITY, TOWN OR LOCATION CLINTON		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 10310 SLOCUM COURT				10f. ZIP CODE 20735		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) TEACHER		16b. KIND OF BUSINESS/INDUSTRY P.G. COUNTY PUBLIC SCHOOLS			
17. FATHER'S NAME (First, Middle, Last) EUGENE WILKINSON				18. MOTHER'S NAME (First, Middle, Maiden Surname) VERNELLE LIVINGSTON			
19a. INFORMANT'S NAME (Type/Print) SHARON JACOBS (DAUGHTER)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10310 SLOCUM COURT, CLINTON, MARYLAND 20735			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HARMONY MEMORIAL PARK 10/27		20c. LOCATION — City or Town, State LANDOVER, MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Alex S. Pope M859				22. NAME AND ADDRESS OF FACILITY ALEXANDER S. POPE FUNERAL HOMES 5538 MARLBORO PIKE, FORESTVILLE, MD. 20747			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Hypertension</u> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death 24 Hrs
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Hepatic myeloidosis</u> <u>Liver hematoma</u>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER Jonisha Medical Intensive Care Unit Resident				29c. LICENSE NUMBER M0 239		29d. DATE SIGNED (Month, Day, Year) 10/22/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Jerry Krishnan 601 NORTH WOLFE ST BALTIMORE 21209 Johns Hopkins Hospital							
31. DATE FILED (Month, Day, Year) OCT 27 1994				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

10 1/9

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760


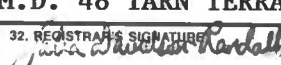
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33622

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HAROLD RICHARD MILLER SR				2. DATE OF DEATH 10 th 29 th 94 th				3. TIME OF DEATH 12:15 P ^M	
4. SOCIAL SECURITY NUMBER 219 14 5323		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 70 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 4, 1924		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) SACRED HEART HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND				9c. COUNTY OF DEATH ALLEGANY	
RESIDENCE OF DECEDENT									
10a. STATE Maryland		10b. COUNTY Allegany		10c. CITY, TOWN OR LOCATION Frostburg				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 160 Mt. Pleasant Street				10f. ZIP CODE 21532		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W.W.II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 				18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Engineering Dept.		16b. KIND OF BUSINESS/INDUSTRY Power Company			
17. FATHER'S NAME (First, Middle, Last) James V. Miller				18. MOTHER'S NAME (First, Middle, Maiden Surname) Carrie Lashbaugh					
19a. INFORMANT'S NAME (Type/Print) Elsie Miller				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 160 Mt. Pleasant Street Frostburg, Maryland 21532					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fbg. Memorial Park		DATE 10/31/94		20c. LOCATION — City or Town, State Frostburg, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Durst Funeral Home 57 Frost Avenue Frostburg, Md. 21532					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pulmonary edema (Massive) DUE TO (OR AS A CONSEQUENCE OF): b. Engorged Heart Failure DUE TO (OR AS A CONSEQUENCE OF): c. Ischemic Cardiomyopathy DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death 2 weeks	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Bilateral Pneumonia. Renal Failure. Hypertension. CANCER Right lung COPD.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER SL Sandhu MD				29c. LICENSE NUMBER D 144 64		29d. DATE SIGNED (Month, Day, Year) 10/30/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SANDHIR, SIKANDER, M.D. 48 TARN TERRACE FROSTBURG, MD. 21532									
31. DATE FILED (Month, Day, Year) NOV 01 1994				32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33623

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) STELLA MAE MILLER				2. DATE OF DEATH MONTH DAY YEAR 10 28 94		3. TIME OF DEATH 2300 P M	
4. SOCIAL SECURITY NUMBER 216-18-1371		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 99 YRS.		7. DATE OF BIRTH (Month, Day, Year) JUNE 15 1895	
8. BIRTHPLACE (State or Foreign Country) PA.				9a. FACILITY NAME (If not institution, give street and number) SACRED HEART HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND	
9c. COUNTY OF DEATH ALLEGANY				10a. STATE MARYLAND		10b. COUNTY ALLEGANY	
10c. CITY, TOWN OR LOCATION FROSTBURG				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 1 KAYLOR CIRCLE FROSTBURG NURSING HOME	
10f. ZIP CODE 21532				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSE KEEPER		16b. KIND OF BUSINESS/INDUSTRY HOUSE KEEPER			
17. FATHER'S NAME (First, Middle, Last) ISAAC HOOK				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY ANN WERTZ			
19a. INFORMANT'S NAME (Type/Print) CHARLEY MILLER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 219 CENTRAL AVE. CUMBERLAND MARYLAND 21502			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) SUNSET CEMETERY OCT 31 1994		20c. LOCATION — City or Town, State Cumberland Maryland		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dale L. Merritt</i>	
22. NAME AND ADDRESS OF FACILITY MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. CONGESTIVE HEART FAILURE DUE TO (OR AS A CONSEQUENCE OF): b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. GANGRENOUS Right Leg. Cerebral Arteriosclerosis DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>			
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>S. Chang MD</i>				29c. LICENSE NUMBER 925638		29d. DATE SIGNED (Month, Day, Year) 10/30/90	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SATURNINA CHANG M.D. RT 36 FROSTBURG PLAZA FROSTBURG MD 21532							
31. DATE FILED (Month, Day, Year) OCT 31 1994				32. REGISTRAR'S SIGNATURE <i>Burton Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


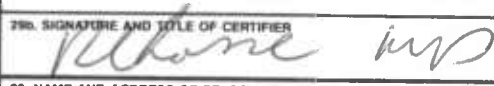
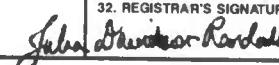
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Amended #104, 11/4/94, L.S., Somerset Co.

94 33624

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) CHARLOTTE S. MUIR				2. DATE OF DEATH MONTH DAY YEAR 11 03 1994		3. TIME OF DEATH 8:55 A.M.			
4. SOCIAL SECURITY NUMBER 218-05-0681		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 76 YRS.		7. DATE OF BIRTH (Month, Day, Year) 03-16-1918		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) 30444 Linden Avenue				9b. CITY, TOWN OR LOCATION OF DEATH Princess Anne			9c. COUNTY OF DEATH Somerset		
10a. STATE Maryland		10b. COUNTY Somerset		10c. CITY, TOWN OR LOCATION Westover Princess Anne			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 28984 Revells Neck Road				10f. ZIP CODE 21871		10g. CITIZEN OF WHAT COUNTRY? U.S.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 11 College (1-4 or 5+) 11		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Restaurant Owner			16b. KIND OF BUSINESS/INDUSTRY Food Service				
17. FATHER'S NAME (First, Middle, Last) William Henry Simms				18. MOTHER'S NAME (First, Middle, Maiden Surname) Cora Chatham					
19a. INFORMANT'S NAME (Type/Print) Mrs. Anne Bounds				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30444 Linden Avenue, Princess Anne, Md.					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Manokin Presbyterian		DATE 11/6		20c. LOCATION — City or Town, State Princess Anne, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  MO0295				22. NAME AND ADDRESS OF FACILITY Hinman Funeral Home Princess Anne, Md. 21853					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. LUNG CANCER DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate interval between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER  MD				29c. LICENSE NUMBER 046080		29d. DATE SIGNED (Month, Day, Year) 11/3/94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert T. Chasse MD 100E. Carroll St. PRMC Station #379 Salisbury, Md 21801									
31. DATE FILED (Month, Day, Year) NOV 04 1994				32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



By - [illegible]

Subscribed by [illegible] APR 21 1904

94 33625

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 10-29-94 2PM

1. DECEDENT'S NAME (First, Middle, Last) Stuart Gillmore Morris				2. DATE OF DEATH MONTH 10 DAY 29 YEAR 94		3. TIME OF DEATH 1400 M	
4. SOCIAL SECURITY NUMBER 217-34-1242		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 62 YRS.		7. DATE OF BIRTH (Month, Day, Year) 8/12/31	
9a. FACILITY NAME (If not institution, give street and number) 17 Carvel St.				9b. CITY, TOWN OR LOCATION OF DEATH Annapolis		9c. COUNTY OF DEATH AA	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Annapolis		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 17 Carvel Drive				10f. ZIP CODE 21401		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Korean		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Sales		16b. KIND OF BUSINESS/INDUSTRY Publications	
17. FATHER'S NAME (First, Middle, Last) Stuart Hagner Gillmore				18. MOTHER'S NAME (First, Middle, Maiden Surname) Cynthia Blackburn			
19a. INFORMANT'S NAME (Type/Print) Eleanor B. Morris				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17 Carvel Drive Annapolis, Maryland 21401			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Christ Episcopal Church Cemetery		20c. LOCATION — City or Town, State West River, Maryland		20d. DATE 11/2/94	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donald A. Taylor</i>				22. NAME AND ADDRESS OF FACILITY John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ASCVD DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Recent Respiratory Distress							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>William P. Jones, MD Deputy</i>				29c. LICENSE NUMBER D06054		29d. DATE SIGNED (Month, Day, Year) 10/31/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) William P. Jones, MD 695 America 21035							
31. DATE FILED (Month, Day, Year) NOV 1 1994				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33626

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JAMES NMN MEOLA		2. DATE OF DEATH MONTH DAY YEAR OCT 30 1994		3. TIME OF DEATH 9:30 A M	
4. SOCIAL SECURITY NUMBER 184-16-4783	5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 76 YRS.	7. DATE OF BIRTH (Month, Day, Year) August 19, 1918	8. BIRTHPLACE (State or Foreign Country) Pennsylvania	
9a. FACILITY NAME (If not institution, give street and number) Bethesda Naval Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Bethesda		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT					
10a. STATE North Carolina	10b. COUNTY Mecklenburg	10c. CITY, TOWN OR LOCATION Charlotte		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1300 Cedar Lane		10f. ZIP CODE 28226		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW-2		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 8		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Administrative Analyst		16b. KIND OF BUSINESS/INDUSTRY University of California	
17. FATHER'S NAME (First, Middle, Last) Alfonse Meola		18. MOTHER'S NAME (First, Middle, Maiden Surname) Marie Anntoinette Rizzo			
19a. INFORMANT'S NAME (Type/Print) Jean Meola		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1300 Cedar Lane, Charlotte, North Carolina 28226			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arlington National Cem. 11-3-94		20c. LOCATION — City or Town, State Arlington, Virginia	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE MGB Mark G. Brohawn Mark G. Brohawn Mooo53		22. NAME AND ADDRESS OF FACILITY THE HUNTT FUNERAL HOME, INC. P.O. BOX 156, WALDORF, MARYLAND 20604			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → RENAL FAILURE DUE TO (OR AS A CONSEQUENCE OF): a. CONGESTIVE HEART FAILURE DUE TO (OR AS A CONSEQUENCE OF): b. CONGESTIVE HEART FAILURE DUE TO (OR AS A CONSEQUENCE OF): c. CONGESTIVE HEART FAILURE DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST					Approximate Interval Between Onset and Death 24 HRS 24 HRS
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER John E. Brown MD.		29c. LICENSE NUMBER D42718 (MO)		29d. DATE SIGNED (Month, Day, Year) 10/30/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOHN E. BROWN, LCDR, MC, USNR NATIONAL NAVAL MEDICAL CENTER BETHESDA, MD 20889-5600					
31. DATE FILED (Month, Day, Year) NOV 03 1994		32. REGISTRAR'S SIGNATURE John Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21205-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33627

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARIE K. ORR				2. DATE OF DEATH MONTH DAY YEAR 10-19-94		3. TIME OF DEATH 6:10 AM M		
4. SOCIAL SECURITY NUMBER 239-34-0332		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 88 YRS.		7. DATE OF BIRTH (Month, Day, Year) 08-28-06		
9a. FACILITY NAME (If not institution, give street and number) MERIDIAN NURSING HOME				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery		
RESIDENCE OF DECEDENT								
10a. STATE Maryland		10b. COUNTY Prince Georges		10c. CITY, TOWN OR LOCATION Seat Pleasant		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		
10e. STREET AND NUMBER 7214 Hylton Street				10f. ZIP CODE 20743		10g. CITIZEN OF WHAT COUNTRY? USA		
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Domestic		16b. KIND OF BUSINESS/INDUSTRY Self-employed				
17. FATHER'S NAME (First, Middle, Last) Frank Knotts				18. MOTHER'S NAME (First, Middle, Maiden Surname)				
19a. INFORMANT'S NAME (Type/Print) Bernard Orr				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7214 Hylton Street, Seat Pleasant, MD 20743				
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Harmony Memorial Pk/ 10/24		20c. LOCATION — City or Town, State Landover, MD				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Julia P. Marshall</i>				22. NAME AND ADDRESS OF FACILITY Marshall's Funeral Home, Inc. 4308 Suitland Rd. Suitland, MD 20746				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Aspiration pneumonia DUE TO (OR AS A CONSEQUENCE OF): b. Colon cancer & obstruction DUE TO (OR AS A CONSEQUENCE OF): c. History of stroke DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death days months years	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		
28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)								
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John Merindino</i>				29c. LICENSE NUMBER D36046		29d. DATE SIGNED (Month, Day, Year) 10/20/94		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John Merindino M.D. 4701 Randolph Rd. Rockville, MD 20852								
31. DATE FILED (Month, Day, Year) OCT 28 1994				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>				

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 6 and 7 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33628

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Charles William Otto, Sr.				2. DATE OF DEATH MONTH 10 DAY 31 YEAR 94		3. TIME OF DEATH 7:48 PM	
4. SOCIAL SECURITY NUMBER 213-05-1477		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 82 YRS.		7. DATE OF BIRTH (Month, Day, Year) 3-13-1909	
9a. FACILITY NAME (If not institution, give street and number) Westminster Nursing Center				9b. CITY, TOWN OR LOCATION OF DEATH Westminster		9c. COUNTY OF DEATH Carroll	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Carroll		10c. CITY, TOWN OR LOCATION Westminster		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 2026 Old Taneytown Road				10f. ZIP CODE 21158		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Worker		16b. KIND OF BUSINESS/INDUSTRY CLEANERS			
17. FATHER'S NAME (First, Middle, Last) Samuel Otto				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lillie Fritz			
19a. INFORMANT'S NAME (Type/Print) Helen Otto				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21158 2026 Old Taneytown Road, Westminster, MD			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt Zion Cemetery 11-3-94		20c. LOCATION — City or Town, State Finksburg			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Katherine Pritts-Swartz				22. NAME AND ADDRESS OF FACILITY Pritts Funeral Home 412 Washington Road, Westminster			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cancer of lung Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]				29c. LICENSE NUMBER 039502		29d. DATE SIGNED (Month, Day, Year) 11/1/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SYED-S. HOSAIN MD, 412 MALCOLM DRIVE, WESTMINSTER MD							
31. DATE FILED (Month, Day, Year) NOV 03 1994				32. REGISTRAR'S SIGNATURE [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21216-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or funeral home for 72 hours after death. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use by the funeral director. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) TIERRA J. OLNEY			2. DATE OF DEATH MONTH DAY YEAR OCT 28 94		3. TIME OF DEATH 5:20 P^M
4. SOCIAL SECURITY NUMBER 217-96-9788	5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 29 YRS.	7. DATE OF BIRTH (Month, Day, Year) 11 23 1964	8. BIRTHPLACE (State or Foreign Country) MARYLAND	
9a. FACILITY NAME (If not institution, give street and number) 213 CLAY STREET			9b. CITY, TOWN OR LOCATION OF DEATH ANNAPOLIS		9c. COUNTY OF DEATH ANNE ARUNDEL
RESIDENCE OF DECEDENT					
10a. STATE MARYLAND	10b. COUNTY ANNE ARUNDEL	10c. CITY, TOWN OR LOCATION ANNAPOLIS		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 213 CLAY STREET		10f. ZIP CODE 21401		10g. CITIZEN OF WHAT COUNTRY? U.S.	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) NURSE ASSISTANT		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) LOUIS OLNEY			18. MOTHER'S NAME (First, Middle, Maiden Surname) BESSIE JOHNSON		
19a. INFORMANT'S NAME (Type/Print) BESSIE FORRESTER			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 212 GROSS AVENUE ANNAPOLIS, MD. 21401		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) ANNAPOLIS MEM. GARDENS		20c. LOCATION — City or Town, State ANNAPOLIS, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Harry S. Reese		22. NAME AND ADDRESS OF FACILITY REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Patrolman gunshot wound Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.					Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 10/28/94		28b. TIME OF INJURY 1710 M	
		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED Subject shot self	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Home		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 213 Clay St.	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER Clara Locke MD			29c. LICENSE NUMBER O.C.M..E		29d. DATE SIGNED (Month, Day, Year) OCT 29, 1994
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Clara Locke, MD 111 Penn Street, Baltimore, Maryland 21201					
31. DATE FILED (Month, Day, Year) NOV 03 1994		32. REGISTRAR'S SIGNATURE John Davidson Randall			

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0026
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33630

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Anna Margaret PEYTON				2. DATE OF DEATH MONTH DAY YEAR Nov 3 1994		3. TIME OF DEATH 7:15 PM	
4. SOCIAL SECURITY NUMBER 214-34-9977		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 7, 1910	
8. FACILITY NAME (If not institution, give street and number) Washington County Hospital				9. CITY, TOWN OR LOCATION OF DEATH Hagerstown		10. COUNTY OF DEATH Washington	
11. RESIDENCE OF DECEDENT 10a. STATE Maryland				10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Hagerstown	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 18010 Par Three Drive			
10f. ZIP CODE 21740				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 0-12		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) housewife		17. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) Raymond Graham Ditto				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ella Nora Downey			
19a. INFORMANT'S NAME (Type/Print) Mrs. Mary Blosser				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 616 Bentley Court, Hagerstown, Maryland 21740			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. View Cemetery		DATE 11-7-94		20c. LOCATION — City or Town, State Sharpsburg, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Frank L. ...</i>				22. NAME AND ADDRESS OF FACILITY Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, MD 21740			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. DUE TO (OR AS A CONSEQUENCE OF): Cardiac Arrest b. DUE TO (OR AS A CONSEQUENCE OF): Acute Myocardial Infarction c. DUE TO (OR AS A CONSEQUENCE OF): ASCVD d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 1 Hr. yrs.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPD.						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Kang, M.D.</i>				29c. LICENSE NUMBER D17027		29d. DATE SIGNED (Month, Day, Year) Nov. 4, 94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) WUN Z KANG, M.D. 19516 Va. Ave. Hagerstown, Md 21740							
31. DATE FILED (Month, Day, Year) NOV 07 1994				32. REGISTRAR'S SIGNATURE <i>John ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33631

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Horace B. Parsley				2. DATE OF DEATH MONTH DAY YEAR October 22, 1994		3. TIME OF DEATH 11:57 P M	
4. SOCIAL SECURITY NUMBER 577-03-2055		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		8. AGE (In yrs. last birthday) 89 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 10, 1905	
9a. FACILITY NAME (If not institution, give street and number) Wilson Health Care Center				9b. CITY, TOWN OR LOCATION OF DEATH Gaithersburg		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Gaithersburg		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 401 Russell Avenue, #308				10f. ZIP CODE 20877		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Contractor		16b. KIND OF BUSINESS/INDUSTRY Home Improvements			
17. FATHER'S NAME (First, Middle, Last) Clarence Parsley				18. MOTHER'S NAME (First, Middle, Maiden Surname) Florence M. Talbott			
19a. INFORMANT'S NAME (Type/Print) Jeanne P. Bulleit				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6403 Orchid Drive, Bethesda, MD 20817			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Suburban Crematory		DATE 10-23		20c. LOCATION — City or Town, State Silver Spring, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ellen H. Rapp				22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequitely ill conditione, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. Hypercalcemia b. Transitional cell carcinoma of bladder c. bony metastasis d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							Approximate Interval Between Onset and Death
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER S. Abulfarag, MD				29c. LICENSE NUMBER 31391D		29d. DATE SIGNED (Month, Day, Year) 10/23/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) #G-10 Suhair H. Abulfarag, M. D., 19261 Montgomery Village Avenue, Gaithersburg, MD 20879							
31. DATE FILED (Month, Day, Year) OCT 24 1994				32. REGISTRAR'S SIGNATURE Gina Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

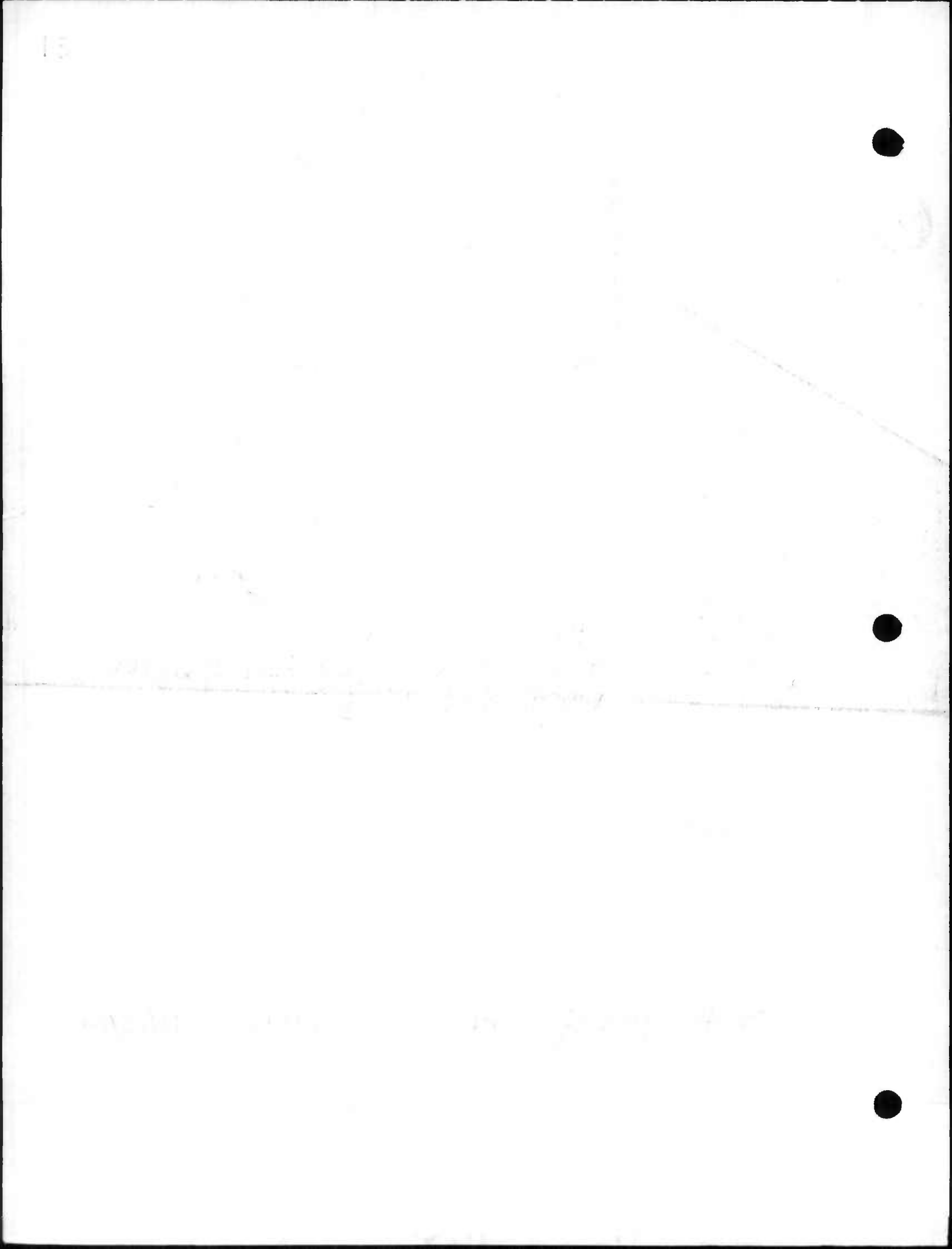
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33632

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Curtis C. Prior				2. DATE OF DEATH MONTH DAY YEAR Oct. 19 1994		3. TIME OF DEATH 6.35 p m	
4. SOCIAL SECURITY NUMBER 011-16-3747		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct. 2, 1920	
9a. FACILITY NAME (If not institution, give street and number) Shady Grove Adventist Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Rockville		9c. COUNTY OF DEATH Montgomery	
10a. STATE MD				10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Gaithersburg	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 9615 Horizon Run Road			
10f. ZIP CODE 20879				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Advertising Specialties		16b. KIND OF BUSINESS/INDUSTRY Advertising	
17. FATHER'S NAME (First, Middle, Last) Unknown				16. MOTHER'S NAME (First, Middle, Maiden Surname) Grace Newman			
19a. INFORMANT'S NAME (Type/Print) Penelope E. Prior				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9615 Horizon Run Rd., Gaithersburg, MD 20879			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 10/24		20c. LOCATION — City or Town, State Silver Spring, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael E. Nelson</i>				22. NAME AND ADDRESS OF FACILITY Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave, NW, Washington, DC 20016			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → MYOCARDIAL INFARCTION							
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
a. DUE TO (OR AS A CONSEQUENCE OF): CAD							
b. DUE TO (OR AS A CONSEQUENCE OF): DM							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER 158457		29d. DATE SIGNED (Month, Day, Year) Oct. 21, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Nakul Goyal, M. D. 3801 International Drive #207 Silver Spring, MD 20906							
31. DATE FILED (Month, Day, Year) OCT 28 1994				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rendell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Amended # 9a

10/27/94 MRT Montgomery County
 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

94 33633

FOR
 STATE
 REGISTRAR

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) JANICE PROCTOR PRESTON				2. DATE OF DEATH MONTH DAY YEAR OCTOBER 24, 1994		3. TIME OF DEATH 4:10 P. M.	
4. SOCIAL SECURITY NUMBER 230-36-5951		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 63 YRS.		7. DATE OF BIRTH (Month, Day, Year) 1930 December 15,	
8. BIRTHPLACE (State or Foreign Country) Virginia				9a. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery	
9b. FACILITY NAME (If not institution, give street and number) 12528 Epping Court				10a. STATE Maryland		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION Silver Spring				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 12528 Epping Court	
10f. ZIP CODE 20906		10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 1 <input type="checkbox"/> College (1-4 or 5+) 1 1/2	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Clerical				16b. KIND OF BUSINESS/INDUSTRY Federal Government		17. FATHER'S NAME (First, Middle, Last) Henry Shirles Proctrr	
18. MOTHER'S NAME (First, Middle, Maiden Surname) Clara Virginia Garrett				19a. INFORMANT'S NAME (Type/Print) Nancy Lynne Trimboli		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2706 Ashmont Terrace Silver Spring, Maryland 20906	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Haynes Cemetery 10/29/94		20c. LOCATION — City or Town, State Mathews, Virginia		21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert E. Ramsay	
22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 20901 500 University Boulevard, W. Sil. Spr., MD				23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>CANCER OF BRAIN</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.		Approximate Interval Between Onset and Death 8 MOS.	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>PARKINSONISM</u>				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>				25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER B. T. Bernack MD		29c. LICENSE NUMBER D5517	
29d. DATE SIGNED (Month, Day, Year) 10/25/94				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) B. T. Bernack MD 4115 Colie DR. Wheaton, MD 20906		31. DATE FILED (Month, Day, Year) OCT 27 1994	
32. REGISTRAR'S SIGNATURE Julia Anderson							

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician to the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33634

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <i>Thelma Jean Palmer</i>				2. DATE OF DEATH MONTH <i>10</i> DAY <i>26</i> YEAR <i>94</i>		3. TIME OF DEATH <i>4:15 A M</i>	
4. SOCIAL SECURITY NUMBER <i>401-30-1308</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>69</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Jul 3 1925</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Harford Memorial Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Harford</i>		9c. COUNTY OF DEATH <i>Harford</i>	
RESIDENCE OF DECEASED							
10a. STATE <i>MD</i>		10b. COUNTY <i>Cecil</i>		10c. CITY, TOWN OR LOCATION <i>Conowingo</i>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>338 E. Red Hill Rd</i>				10f. ZIP CODE <i>21918</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>white</i>	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>College</i>				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Home</i>	
17. FATHER'S NAME (First, Middle, Last) <i>Arthur Lockhart</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Lillie Baumgardner</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Delores A Graybeal</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>300 E Red Hill Rd Conowingo MD 21918</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>West Nottingham 10-29-1994</i>		20c. LOCATION — City or Town, State <i>Coloma MD</i>		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <i>R T Foard Funeral Home 111 S Queen St Rising Sun MD 21911</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Aspiration</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <div style="display: flex; align-items: center;"> <div style="font-size: 3em; margin-right: 10px;">{</div> <div> <p>b. <i>GI bleeding</i> DUE TO (OR AS A CONSEQUENCE OF):</p> <p>c. <i>Thyroidal Abdominal Cancer</i> DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d. <i>S</i> DUE TO (OR AS A CONSEQUENCE OF):</p> </div> </div>							Approximate Interval Between Onset and Death <i>hours</i> <i>1 dg</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature] M.D.</i>				29c. LICENSE NUMBER <i>D25597</i>		29d. DATE SIGNED (Month, Day, Year) <i>10/26/94</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>A. P. CARLIS M.D. 504 Lewis St. HALE MD 21078</i>							
31. DATE FILED (Month, Day, Year) <i>OCT 28 '94</i>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33635

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Fernando Villareal Pantorilla				2. DATE OF DEATH MONTH DAY YEAR October 23, 1994		3. TIME OF DEATH 7:40P M	
4. SOCIAL SECURITY NUMBER 563-52-4182		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 94 YRS.		7. DATE OF BIRTH (Month, Day, Year) 5/30/1900	
9a. FACILITY NAME (If not institution, give street and number) Malcolm Grow Medical Center				9b. CITY, TOWN OR LOCATION OF DEATH Camp Springs		9c. COUNTY OF DEATH Prince George's	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Ft. Washington		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 9101 Aqua-Lynn Ct.				10f. ZIP CODE 20744		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Retired 1947		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Filipino	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6th		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) US Army		16b. KIND OF BUSINESS/INDUSTRY Military			
17. FATHER'S NAME (First, Middle, Last) Numeriano Pantorilla				18. MOTHER'S NAME (First, Middle, Maiden Surname) Juanita Villareal			
19a. INFORMANT'S NAME (Type/Print) Teresita P. Soriano				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as item 10			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arlington National Cem. 10/26/94		20c. LOCATION — City or Town, State Arlington, Va.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George P. Kalas</i>				22. NAME AND ADDRESS OF FACILITY George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md. 20745			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arrhythmia DUE TO (OR AS A CONSEQUENCE OF): b. Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal Failure, Aortic Stenosi, Congestive Heart Failure DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Watson</i>				29c. LICENSE NUMBER 17085 SC		29d. DATE SIGNED (Month, Day, Year) Oct. 23, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Karen Leigh Watson, Capt, USAF, MC 89 Medical Group Andrews AFB MD 20331-6600							
31. DATE FILED (Month, Day, Year) OCT 25 1994				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

7, 10/27/94, C.V.W.
Amended # 206. 10/19/94, C.V.W., P.G.C.H.D.

94 33636

1 -
FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Peggy M. Phillips				2. DATE OF DEATH MONTH DAY YEAR Oct. 14, 1994				3. TIME OF DEATH 12:05 a.m.			
4. SOCIAL SECURITY NUMBER 214-28-4774		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 63 YRS.		7. DATE OF BIRTH (Month, Day, Year) Apr. 30, 1931		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) The Johns Hopkins Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore				9c. COUNTY OF DEATH Baltimore City			
RESIDENCE OF DECEDENT											
10a. STATE Maryland		10b. COUNTY Prince Georges		10c. CITY, TOWN OR LOCATION Bladensburg				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 4929 56th Place				10f. ZIP CODE 20710		10g. CITIZEN OF WHAT COUNTRY? United States					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4 or 5+) 11th				18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker			16b. KIND OF BUSINESS/INDUSTRY Own Home				
17. FATHER'S NAME (First, Middle, Last) Arthur C. Sampson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Bessie Inez Chafin							
19a. INFORMANT'S NAME (Type/Print) Wilbert E. Phillips				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4929 56th Place, Bladensburg, Maryland 20710							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Cemetery 10/17/94		20c. LOCATION — City or Town, State Brentwood, Maryland							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Fort Lincoln Funeral Home, Inc. 3401 Bladensburg Rd., Brentwood, MD 20722							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cirrhosis DUE TO (OR AS A CONSEQUENCE OF): b. Alcoholism DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 4 Years 30 Years								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal Failure, Bleeding duodenal ulcer, Hepatic Encephalopathy DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER L8820		29d. DATE SIGNED (Month, Day, Year) October 18, 1994			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Peter Braverman, Johns Hopkins Hospital, 600 N. Wolfe St., Baltimore, MD											
31. DATE FILED (Month, Day, Year) OCT 19 1994				32. REGISTRAR'S SIGNATURE 							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit and filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33637

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Jeanne Perkins</i>		2. DATE OF DEATH MONTH DAY YEAR <i>October 23, 1994</i>		3. TIME OF DEATH <i>3P</i>	
4. SOCIAL SECURITY NUMBER 438-34-4931		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 66 YRS.	
7. DATE OF BIRTH (Month, Day, Year) SEPT 8, 1928		8. BIRTHPLACE (State or Foreign Country) NEW ORLEANS, LA.			
9a. FACILITY NAME (If not institution, give street and number) 10301 BUENA VISTA AVENUE		9b. CITY, TOWN OR LOCATION OF DEATH LANHAM		9c. COUNTY OF DEATH PRINCE GEORGE'S	
10a. STATE MARYLAND		10b. COUNTY PRINCE GEORGE'S		10c. CITY, TOWN OR LOCATION LANHAM	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 10301 BUENA VISTA AVENUE		10f. ZIP CODE 20706	
10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) College	
16. KINO OF BUSINESS/INDUSTRY PRIVATE		17. FATHER'S NAME (First, Middle, Last) HENRY PERKINS		18. MOTHER'S NAME (First, Middle, Maiden Surname) NADDIER BICKHAM	
19a. INFORMANT'S NAME (Type/Print) NADIA BROWN (DAUGHTER)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10804 SAVILLE COURT, MITCHELLVILLE, MARYLAND 20721			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) WASHINGTON NATIONAL CEM. 10/27/94		20c. LOCATION — City or Town, State SUITLAND, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Guawana L. Blaxton</i>		22. NAME AND ADDRESS OF FACILITY J.B. JENKINS FUNERAL HOME 7474 LANDOVER RD, LANDOVER, MARYLAND 20785			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Hypertensive infarct of the brain</i> DUE TO (OR AS A CONSEQUENCE OF): <i>disease</i> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Augusto P. Rodriguez MD</i>		29c. LICENSE NUMBER <i>D21230</i>		29d. DATE SIGNED (Month, Day, Year) <i>October 23, 1994</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Augusto P. Rodriguez MD, 5009 Rayburn Ct, Cp 3rd MD 20748</i>		31. DATE FILED (Month, Day, Year) <i>OCT 27 1994</i>			
32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 may be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33638

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) SUSAN MARY PASSARELLI				2. DATE OF DEATH MONTH 10 DAY 28 YEAR 94		3. TIME OF DEATH 3:11 P M	
4. SOCIAL SECURITY NUMBER 218-48-9246		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 90 YRS.		7. DATE OF BIRTH (Month, Day, Year) 02 28 04	
9a. FACILITY NAME (If not institution, give street and number) SACRED HEART HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND		9c. COUNTY OF DEATH ALLEGANY	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Allegany		10c. CITY, TOWN OR LOCATION Frostburg		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 27 First Street				10f. ZIP CODE 21532		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Domestic			
17. FATHER'S NAME (First, Middle, Last) Luigi Arnone				18. MOTHER'S NAME (First, Middle, Maiden Surname) Concetta Gualteri			
19a. INFORMANT'S NAME (Type/Print) Msgr. Robert S. Passarelli				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 First Street Frostburg, Maryland 21532			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Michaels Cemetery 10/31/94		20c. LOCATION — City or Town, State Frostburg, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John P. Horn</i>				22. NAME AND ADDRESS OF FACILITY Durst Funeral Home 57 Frost Avenue Frostburg, Maryland 21532			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute Diverticulitis							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
a. DUE TO (OR AS A CONSEQUENCE OF): Diverticulosis							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Bowel Obstruction - Congestive Heart Failure Hypertension							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Victor E. Mazzocco</i>				29c. LICENSE NUMBER D07135		29d. DATE SIGNED (Month, Day, Year) 11-1-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) VICTOR E. MAZZOCCO M.D. 912 SETON DRIVE CUMBERLAND, MD. 21502							
31. DATE FILED (Month, Day, Year) NOV 01 1994				32. REGISTRAR'S SIGNATURE <i>John A. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33639

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LOLA GRACE PUSEY				2. DATE OF DEATH MONTH 11 DAY 2 YEAR 94		3. TIME OF DEATH 4:00 P.M.	
4. SOCIAL SECURITY NUMBER 216-16-7245		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		7. DATE OF BIRTH (Month, Day, Year) 6/24/21	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) 12073 Crisfield Lane		9b. CITY, TOWN OR LOCATION OF DEATH Princess Anne	
9c. COUNTY OF DEATH Somerset				10a. STATE Maryland		10b. COUNTY Somerset	
10c. CITY, TOWN OR LOCATION Princess Anne				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 12073 Crisfield Lane	
10f. ZIP CODE 21853				10g. CITIZEN OF WHAT COUNTRY? U.S.		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Clerk		16b. KIND OF BUSINESS/INDUSTRY Retail Sales	
17. FATHER'S NAME (First, Middle, Last) Ernest Stant				18. MOTHER'S NAME (First, Middle, Maiden Surname) Annie Bridell Stant			
19a. INFORMANT'S NAME (Type/Print) Milton Wayne Pusey				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12073 Crisfield Lane, Princess Anne, Md. 21853			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Beechwood Cemetery 11/5 Princess Anne, Md.		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James L. Hill Jr.</i> M00295				22. NAME AND ADDRESS OF FACILITY Hinman Funeral Home Princess Anne, Md. 21853			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Carcinoma of Lung with Metastases DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):				Approximate Interval Between Onset and Death 6 years			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER Thomas C. Hill Jr. Attending Physician			
29c. LICENSE NUMBER D 08008				29d. DATE SIGNED (Month, Day, Year) 11-03-94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Thomas C. Hill Jr. 108 Pine Bluff Rd., Salisbury, Md 21801							
31. DATE FILED (Month, Day, Year) NOV 04 1994				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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94 33640

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MAZIE DEAN PRITCHETT				2. DATE OF DEATH MONTH DAY YEAR Oct. 31 1994		3. TIME OF DEATH 6:30 pm M	
4. SOCIAL SECURITY NUMBER 214-07-9946		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) 92 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 28 1902	
9a. FACILITY NAME (If not institution, give street and number) William Hill Health Care Center		9b. CITY, TOWN OR LOCATION OF DEATH Cambridge		9c. COUNTY OF DEATH Dorchester			
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Dorchester		10c. CITY, TOWN OR LOCATION Cambridge		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 906 Race St.				10f. ZIP CODE 21613		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 6		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) homemaker		15b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) Walter E. Dean				18. MOTHER'S NAME (First, Middle, Maiden Surname) Florence E. Andrews			
19a. INFORMANT'S NAME (Type/Print) Mrs. Sybil Pritchett				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5132 North Drive, Cambridge MD 21613			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cambridge Cemetery 11/2		20c. LOCATION — City or Town, State Cambridge Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Kenneth R. Thomas Jr.</i>				22. NAME AND ADDRESS OF FACILITY Thomas Funeral Home 700 Locust St., Cambridge MD 21613			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>CANCER OF COLON</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate interval Between Onset and Death <i>See History</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</u>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>W. S. Shariff</i>				29c. LICENSE NUMBER 015665		29d. DATE SIGNED (Month, Day, Year) 11/6/99	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) M. S. SHARIFF, MD 105 AURORA ST. CAMBRIDGE MD 21613							
31. DATE FILED (Month, Day, Year) NOV 02 1994				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



RECEIVED

RECEIVED

RECEIVED

94 33641

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>William Harvey Quick</i>				2. DATE OF DEATH MONTH DAY YEAR <i>October 21, 1994</i>		3. TIME OF DEATH <i>9:00A</i>	
4. SOCIAL SECURITY NUMBER <i>577-26-9124A</i>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>84</i> YRS.		7. DATE OF BIRTH MONTH DAY YEAR <i>4/9/10</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>DOCTOR'S HOSPITAL</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>LANHAM</i>		9c. COUNTY OF DEATH <i>PG</i>	
10a. STATE <i>DC</i>				10b. COUNTY <i>N/A</i>		10c. CITY, TOWN OR LOCATION <i>Washington</i>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER <i>1540 Douglas St NE</i>			
10f. ZIP CODE <i>20018-2010</i>				10g. CITIZEN OF WHAT COUNTRY?			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. <i>Black</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i> <i>12 Yrs</i>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Carpentry (Self-Employed)</i>		15b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <i>Adams Evans Quick</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Mary Jane Mitchell</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Mayme G. Quick</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>Same as 13a,b,c,d,e,&f</i>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, church, or other place) <i>Lincoln Cemetery</i>		20c. LOCATION — City or Town, State <i>Brentwood, Md.</i>		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Juan Smith</i>				22. NAME AND ADDRESS OF FACILITY <i>John T. Rhines Co., Inc. 3030 12th St NE, DC 20017</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Aspiration Pneumonia</i> a. _____ DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Prostate cancer</i> <i>Cerebrovascular disease</i>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. PLACE OF DEATH (Check only one) OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. DATE SIGNED (Month, Day, Year) <i>10-21-94</i>			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>George C. Hajjar, Jr.</i>				29c. LICENSE NUMBER <i>039550</i>		29d. DATE SIGNED (Month, Day, Year)	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>George C. Hajjar, Jr. M.D. 4850 Forbes Blvd. Landover, Md 20706</i>							
31. DATE FILED (Month, Day, Year) <i>OCT 24 1994</i>				32. REGISTRAR'S SIGNATURE <i>Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33642

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Hazel Jean Reckart				2. DATE OF DEATH MONTH DAY YEAR Oct. 13, 1994				3. TIME OF DEATH 2:50 P M					
4. SOCIAL SECURITY NUMBER 213-72-4817		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 59 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Jan. 26, 1935		8. BIRTHPLACE (State or Foreign Country) West Virginia			
9a. FACILITY NAME (If not institution, give street and number) Garrett County Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Oakland				9c. COUNTY OF DEATH Garrett					
RESIDENCE OF DECEDENT													
10a. STATE MD		10b. COUNTY Garrett		10c. CITY, TOWN OR LOCATION Oakland				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER Star Rt. 2, Box 131				10f. ZIP CODE 21550				10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife				16b. KIND OF BUSINESS/INDUSTRY Home					
17. FATHER'S NAME (First, Middle, Last) Orville M. Wolfe				18. MOTHER'S NAME (First, Middle, Maiden Surname) Laura Ethel Liston									
19a. INFORMANT'S NAME (Type/Print) Clayton C. Reckart				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Star Rt. 2, Box 131, Oakland, Maryland 21550									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Ashby Cemetery				DATE 10/16		20c. LOCATION — City or Town, State Oakland, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Bradley A. Howard				22. NAME AND ADDRESS OF FACILITY Stewart Funeral Home 32 S. Second St., Oakland, MD 21550									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acidosis DUE TO (OR AS A CONSEQUENCE OF): b. Severe Peripheral Vascular Disease DUE TO (OR AS A CONSEQUENCE OF): c. Diabetes Mellitus DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST										Approximate interval Between Onset and Death Hours Years Years			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal Failure on Digoxin										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED			
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER						29c. LICENSE NUMBER D26568			29d. DATE SIGNED (Month, Day, Year) 10/14/94				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Roger A. Lewis, MD 510 W. State St., Terra Alta, West Virginia 26764													
31. DATE FILED (Month, Day, Year) OCT 19 1994				32. REGISTRAR'S SIGNATURE John Dawson-Randall									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33643

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ARNOLD NMN RODGAARD				2. DATE OF DEATH MONTH DAY YEAR NOVEMBER 2, 1994		3. TIME OF DEATH 7:50 PM	
4. SOCIAL SECURITY NUMBER 157-07-0660		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10-25-1917	
8. BIRTHPLACE (State or Foreign Country) New Jersey				9. CITY, TOWN OR LOCATION OF DEATH Hagerstown			
10. COUNTY OF DEATH Washington				11. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
12. FACILITY NAME (If not institution, give street and number) Washington County Hospital				13. CITY, TOWN OR LOCATION OF DEATH Hagerstown			
14. STATE Maryland				15. COUNTY Washington			
16. CITY, TOWN OR LOCATION Hagerstown				17. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
18. STREET AND NUMBER 18506 Indian Cottage Road				19. ZIP CODE 21742		20. CITIZEN OF WHAT COUNTRY? U.S.A.	
21. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		22. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES World War II		23. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		24. RACE — American Indian, Black, White, etc. Specify: White	
25. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 years		26. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Transmission Assembler		27. KIND OF BUSINESS/INDUSTRY Truck Mfg.			
28. FATHER'S NAME (First, Middle, Last) Hans Rodgaard				29. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Christine Sorensen			
30. INFORMANT'S NAME (Type/Print) Helena M.K. McCowen Rodgaard				31. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18506 Indian Cottage Road Hagerstown, Md. 21742			
32. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		33. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Rest Haven Cemetery 11-5-1994		34. DATE 11-5-1994		35. LOCATION — City or Town, State Hagerstown, Maryland	
36. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Douglas A. Fiery</i>				37. NAME AND ADDRESS OF FACILITY Douglas A. Fiery Funerak Home 1331 Eastern Blvd. North Hagerstown, Maryland			
38. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Myocardial Infarction</i> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <i>Atherosclerotic heart disease</i> a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
39. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
40. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		41. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
42. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		43. DATE OF INJURY (Month, Day, Year)		44. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		45. DESCRIBE HOW INJURY OCCURRED	
46. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		47. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
48. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
49. SIGNATURE AND TITLE OF CERTIFIER <i>J. Henrich MD</i>				50. LICENSE NUMBER		51. DATE SIGNED (Month, Day, Year) 11/2/94	
52. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. Henrich MD, 12821 Oak hill ave, Hagerstown, MD 21740							
53. DATE FILED (Month, Day, Year) NOV 04 1994				54. REGISTRAR'S SIGNATURE <i>J. Henrich</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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94 33644

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) RONA MARIE RANDALL				2. DATE OF DEATH MONTH 10 DAY 23 YEAR 1994		3. TIME OF DEATH 1735 M	
4. SOCIAL SECURITY NUMBER 217-36-7959		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 59 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 16, 1935	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Frederick Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Frederick	
9c. COUNTY OF DEATH FREDERICK				10a. STATE Maryland		10b. COUNTY Frederick	
10c. CITY, TOWN OR LOCATION Frederick				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 1208 Aynsley Court, Apt. 1D	
10f. ZIP CODE 21702				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4 or 5+) 		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Home Maker		16b. KIND OF BUSINESS/INDUSTRY Home			
17. FATHER'S NAME (First, Middle, Last) Asbury Zeigler				18. MOTHER'S NAME (First, Middle, Maiden Surname) Bertha Lyles			
19a. INFORMANT'S NAME (Type/Print) Wanita Lyles (Daughter)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) LL102 Waverly Dr., Frederick, MD 21702			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Friendship Cemetery 10/28		20c. LOCATION — City or Town, State Damascus, MD		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George R. Snowden</i>	
22. NAME AND ADDRESS OF FACILITY SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO						25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>John A. Vitarello</i>	
29c. LICENSE NUMBER D 27544		29d. DATE SIGNED (Month, Day, Year) 10/23/94		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John A. Vitarello, M.D. 310 W. 9th Street, Frederick, MD 21701			
31. DATE FILED (Month, Day, Year) OCT 28 1994		32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

94 33645

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Helen Nelson Rinaudot				2. DATE OF DEATH MONTH DAY YEAR October 21, 1994		3. TIME OF DEATH 2:00 P. M.	
4. SOCIAL SECURITY NUMBER 577-42-3723		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec. 19, 1910	
8. BIRTHPLACE (State or Foreign Country) Pennsylvania				9a. CITY, TOWN OR LOCATION OF DEATH Rockville		9c. COUNTY OF DEATH Montgomery	
9b. FACILITY NAME (If not institution, give street and number) Potomac Valley Nursing Home				10. RESIDENCE OF DECEDENT			
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Rockville		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1235 Potomac Valley Road				10f. ZIP CODE 20850		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) John Nelson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Brennan			
19a. INFORMANT'S NAME (Type/Print) Joanne M. Krohn				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 910 Colony Lane, Lincoln, Nebraska 69505			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc. 10/23/94		20c. LOCATION — City or Town, State Bethesda, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSER Will E. Baer		22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): Cardiomyopathy Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal Failure							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Joel R. Schulman, M.D.				29c. LICENSE NUMBER D20518		29d. DATE SIGNED (Month, Day, Year) 10/24/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Joel R. Schulman, M.D. 9410 Old Georgetown Road, Bethesda, Maryland 20814							
31. DATE FILED (Month, Day, Year) OCT 24 1994				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Amended #1 10/25/94 MRT Montgomery County 94 33646

FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>RUHL, VERONA ZIMMERLI</u>				2. DATE OF DEATH MONTH DAY YEAR October 21, 1994				3. TIME OF DEATH 10:15 P M							
4. SOCIAL SECURITY NUMBER 577-30-6423		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 84 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 7, 1910		8. BIRTHPLACE (State or Foreign Country) Washington, D.C.							
9a. FACILITY NAME (If not institution, give street and number) Randolph Hills Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring				9c. COUNTY OF DEATH Montgomery							
10a. STATE Maryland				10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER 13407 Clifton Road				10f. ZIP CODE 20904		10g. CITIZEN OF WHAT COUNTRY? United States									
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White									
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 10		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Home											
17. FATHER'S NAME (First, Middle, Last) Charles E. Zimmerli				18. MOTHER'S NAME (First, Middle, Maiden Surname) Emily Schleunig											
19a. INFORMANT'S NAME (Type/Print) Gwynethe R. Sanders				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13407 Clifton Road, Silver Spring, Maryland 20904											
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Edge Hill Cemetery 10/25		20c. LOCATION — City or Town, State Charlestown, W. Virginia											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Atherosclerotic Coronary Vascular Disease</u> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):								Approximate Interval Between Onset and Death years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED							
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD		29c. LICENSE NUMBER D34032		29d. DATE SIGNED (Month, Day, Year) 10/22/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JEANNE P. ASHER MD 3720 FARRAGUT AVE KENSINGTON MD 20895										31. DATE FILED (Month, Day, Year) OCT 25 1994		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transcript. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33647

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Elizabeth Reed</i>				2. DATE OF DEATH MONTH <i>10</i> DAY <i>18</i> YEAR <i>94</i>				3. TIME OF DEATH <i>9:26 PM</i>					
4. SOCIAL SECURITY NUMBER <i>577-07-3404</i>				5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>87</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>FEB. 9 1907</i>		8. BIRTHPLACE (State or Foreign Country) <i>WEST VIRGINIA</i>			
9a. FACILITY NAME (If not institution, give street and number) <i>NATIONAL LUTHERAN HOME</i>						9b. CITY, TOWN OR LOCATION OF DEATH <i>ROCKVILLE</i>			9c. COUNTY OF DEATH <i>MONTGOMERY CO</i>				
RESIDENCE OF DECEDENT													
10a. STATE <i>MD.</i>		10b. COUNTY <i>MONTGOMERY</i>		10c. CITY, TOWN OR LOCATION <i>SILVER SPRING</i>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER <i>3367 - S. LEISURE BLVD.</i>				10f. ZIP CODE <i>20906</i>				10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <i>WHITE</i>				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i></i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>OFFICE WORK</i>				16b. KIND OF BUSINESS/INDUSTRY <i>OFFICE</i>					
17. FATHER'S NAME (First, Middle, Last) <i>ALBERT RUFUS CROUCH</i>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>MISSOURI COHERLY</i>							
19a. INFORMANT'S NAME (Type/Print) <i>REV. DR. REICHARD</i>						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>9701-VEIRS DR. ROCKVILLE, MD.</i>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>GLENWOOD CEM 10/21</i>				20c. LOCATION — City or Town, State <i>WASH. D.C.</i>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>W. W. Hyson</i>						22. NAME AND ADDRESS OF FACILITY <i>HYSONG CO. INC. 1300-N ST. N.W. WASH. DC</i>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Pneumonia</i>													
DUE TO (OR AS A CONSEQUENCE OF):													
<i>Parkinson's disease</i>													
DUE TO (OR AS A CONSEQUENCE OF):													
<i>atherosclerotic cardiovascular disease</i>													
DUE TO (OR AS A CONSEQUENCE OF):													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO													
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				26a. DATE OF INJURY (Month, Day, Year)		26b. TIME OF INJURY <i>M</i>		26c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		26d. DESCRIBE HOW INJURY OCCURRED			
26a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Charles W. Karesch</i>						29c. LICENSE NUMBER <i>D21726</i>		29d. DATE SIGNED (Month, Day, Year) <i>10/19/94</i>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>DR. CHARLES W. KARESCH, 9701-VEIRS DR. ROCKVILLE MD</i>													
31. DATE FILED (Month, Day, Year) <i>OCT 24 1994</i>				32. REGISTRAR'S SIGNATURE <i>John T. ...</i>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33648

Item 10g, g-729, 11-15-95, perf. h., dk

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mariano L. Ramos				2. DATE OF DEATH MONTH DAY YEAR October 20, 1994		3. TIME OF DEATH 8:11P M	
4. SOCIAL SECURITY NUMBER 217-29-4520		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 76 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct. 18, 1918	
9a. FACILITY NAME (If not institution, give street and number) Shady Grove Adventist Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Rockville		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland				10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Gaithersburg	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 18402 Honeylocust Circle			
10f. ZIP CODE 20879				10g. CITIZEN OF WHAT COUNTRY? Peru			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: Peruvian		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) — College (1-4 or 5+) 5+				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Engineer		16b. KIND OF BUSINESS/INDUSTRY Farming	
17. FATHER'S NAME (First, Middle, Last) Oscar Ramos				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mercedes Dammert			
19a. INFORMANT'S NAME (Type/Print) Zoyla J. Ramos				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18402 Honeylocust Circle, Gaithersburg, MD 20879			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cementerio Jardines de la Paz 10/26/94		20c. LOCATION — City or Town, State Lima, Peru			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Michael P. Kutta M00348				22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Rockville, Inc., 300 W. Montgomery Ave., Rockville, Maryland 20850-2805			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardio Respiratory arrest DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Myocardial Infarct DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Prostate Carcinoma with bone metastasis							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Hugo G. Graziani M.D.				29c. LICENSE NUMBER D08188		29d. DATE SIGNED (Month, Day, Year) Oct. 21, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) Hugo G. Graziani, M.D., 717 Pershing Drive, Silver Spring, MD 20910-4321							
31. DATE FILED (Month, Day, Year) OCT 24 1994				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician to the FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. To be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33649

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Maria Dianne Ruzicska				2. DATE OF DEATH October 25, 1994		3. TIME OF DEATH 1435 pm	
4. SOCIAL SECURITY NUMBER 500-34-7675		5. SEX 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 88 YRS.		7. DATE OF BIRTH (Month, Day, Year) November 3, 05	
8. BIRTHPLACE (State or Foreign Country) Hungary		9a. FACILITY NAME (If not institution, give street and number) Calvert Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Prince Frederick		9c. COUNTY OF DEATH Calvert	
10a. STATE Maryland				10b. COUNTY Calvert		10c. CITY, TOWN OR LOCATION St. Leonard	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 1569 Overlook Drive		10f. ZIP CODE 20685	
10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: white		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) map maker		16b. KIND OF BUSINESS/INDUSTRY U.S. Government	
17. FATHER'S NAME (First, Middle, Last) Micsege, George				18. MOTHER'S NAME (First, Middle, Maiden Surname) Maria Serfozo			
19a. INFORMANT'S NAME (Type/Print) Joseph Ruzicska				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 248 Carson St. Hercules, Ca. 94547			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 10/29/94		20c. LOCATION — City or Town, State Silver Spring, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>B. Rausch</i>				22. NAME AND ADDRESS OF FACILITY Rausch Funeral Home P.A. 4405 Broomes Is. Rd. Port Republic Maryland			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>CARCINOMA sigmoid</i> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. <i>Neutropenia</i>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Issam Damalouji</i>				29c. LICENSE NUMBER D03077		29d. DATE SIGNED (Month, Day, Year) 10-27-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Issam Damalouji Prince Frederick, MD 20678							
31. DATE FILED (Month, Day, Year) OCT 28 1994				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33650

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Gerda J. E. Roth				2. DATE OF DEATH MONTH DAY YEAR October 23 94		3. TIME OF DEATH 1445 M	
4. SOCIAL SECURITY NUMBER 133-16-0961		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 2, 1922	
9a. FACILITY NAME (If not institution, give street and number) Union Hospital of Cecil County				9b. CITY, TOWN OR LOCATION OF DEATH Elkton		9c. COUNTY OF DEATH Cecil	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Cecil		10c. CITY, TOWN OR LOCATION Elkton		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 459 Bow Street				10f. ZIP CODE 21921		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College (1-4 or 5+)				18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) Max B. Berman				18. MOTHER'S NAME (First, Middle, Maiden Surname) Hendrika G. Schornagel			
19a. INFORMANT'S NAME (Type/Print) Caroline Berman				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 305 King Street - Elkton, MD 21921			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gilpin Manor Memorial Park 10-28 1994		20c. LOCATION — City or Town, State Elkton, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donald S. Hicks</i>				22. NAME AND ADDRESS OF FACILITY Hicks Home for Funerals, P.A. 103 West Stockton Street Elkton, MD 21921-5521			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. <i>Perforated viscous.</i> DUE TO (OR AS A CONSEQUENCE OF):							
b. <i>Septic shock.</i> DUE TO (OR AS A CONSEQUENCE OF):							
c. <i>acute myocardial infarction</i> DUE TO (OR AS A CONSEQUENCE OF):							
d. <i>Schizophrenia</i> DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jui-chih Hsu M.D.</i>				29c. LICENSE NUMBER D04823		29d. DATE SIGNED (Month, Day, Year) 10/25/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Jui-chih Hsu, MD 223 West main st. Elkton MD 21921							
31. DATE FILED (Month, Day, Year) Oct 28 '94				32. REGISTRAR'S SIGNATURE <i>Juha Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020


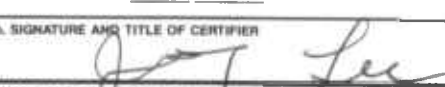
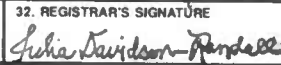
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit certificate. 2. 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33651

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Patricia Jane Rausch				2. DATE OF DEATH MONTH DAY YEAR October 24, 1994		3. TIME OF DEATH 7:54 A.M.	
4. SOCIAL SECURITY NUMBER 212-42-4460		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 50 YRS.		7. DATE OF BIRTH (Month, Day, Year) 3-20-44	
9a. FACILITY NAME (If not institution, give street and number) Harford Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Havre de Grace		9c. COUNTY OF DEATH Harford	
RESIDENCE OF DECEDENT							
10a. STATE Md.		10b. COUNTY Cecil		10c. CITY, TOWN OR LOCATION Conowingo		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 6 Shady Lane				10f. ZIP CODE 21918		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY at home			
17. FATHER'S NAME (First, Middle, Last) Paul Joseph Soash				18. MOTHER'S NAME (First, Middle, Maiden Surname) Fannie Berry			
19a. INFORMANT'S NAME (Type/Print) William J. Rausch, Sr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Shady Lane, Conowingo, Md. 21918			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) K. A. Ferris & Co.		DATE 		20c. LOCATION — City or Town, State West Chester, Pa.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Gee Funeral Home 259 E. Main St., Elkton, Md. 21921			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiac arrest Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Auto M.I. CAD HASOP.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED 				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) 			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  M.D.				29c. LICENSE NUMBER 120661		29d. DATE SIGNED (Month, Day, Year) 10/24/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. F. LEE M.D. 307 S. Union Ave. Havre de Grace MD 21078							
31. DATE FILED (Month, Day, Year) OCT 28 '94				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit form. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33652

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) GAIL ANN ROMANEK				2. DATE OF DEATH MONTH 10 DAY 21 YEAR 94		3. TIME OF DEATH 1505 M	
4. SOCIAL SECURITY NUMBER 579 42 9061		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 59 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 22 1934	
8a. FACILITY NAME (If not institution, give street and number) Anne Arundel Medical Center				8b. CITY, TOWN OR LOCATION OF DEATH Annapolis		8c. BIRTHPLACE (State or Foreign Country) Washington D.C.	
9. COUNTY OF DEATH Anne Arundel							
10a. STATE Maryland				10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Edgewater	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 1222 Daves Road				10f. ZIP CODE 21037		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES NO		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: No		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary		16b. KIND OF BUSINESS/INDUSTRY College			
17. FATHER'S NAME (First, Middle, Last) Ralph S. Payne				18. MOTHER'S NAME (First, Middle, Maiden Surname) Martha Reese			
19a. INFORMANT'S NAME (Type/Print) Stanley J. Romanek				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1222 Daves Rd. Edgewater Maryland 21037			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Maryland Veterans Cemetery		20c. LOCATION — City or Town, State Cheltenham, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert E. Evans, Pres.				22. NAME AND ADDRESS OF FACILITY Beall-Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Md. 20715			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → RESPIRATORY INSUFFICIENCY Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. METASTATIC LUNG CANCER c. d. Approximate Interval Between Onset and Death 1 MONTH 2 YEARS							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Robert E. Evans MD		29c. LICENSE NUMBER D16364		29d. DATE SIGNED (Month, Day, Year) 10/21/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) OCT 25 1994				32. REGISTRAR'S SIGNATURE John Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

NEW YORK

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NEW YORK



94 33653

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Frances Hardy Rose				2. DATE OF DEATH MONTH DAY YEAR October 20, 1994		3. TIME OF DEATH 11:30 P M	
4. SOCIAL SECURITY NUMBER 223-12-9042		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 80 YRS.	7. DATE OF BIRTH (Month, Day, Year) July 16, 1914		8. BIRTHPLACE (State or Foreign Country) Virginia	
9a. FACILITY NAME (If not institution, give street and number) 3512 55th Avenue				9b. CITY, TOWN OR LOCATION OF DEATH Hyattsville		9c. COUNTY OF DEATH Prince George's	
10a. STATE Maryland				10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Hyattsville	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER 3512 55th Avenue				10f. ZIP CODE 20784		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Caucasian	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Assistant Director of Distribution		16b. KIND OF BUSINESS/INDUSTRY Naval Oceanographic Office U.S. Government			
17. FATHER'S NAME (First, Middle, Last) Joseph Arthur Hardy				18. MOTHER'S NAME (First, Middle, Maiden Surname) Verna G. (Maiden Name Unavailable)			
19a. INFORMANT'S NAME (Type/Print) Joseph W. Rose				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3512 55th Avenue, Hyattsville, Md. 20784			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Cemetery 10/24/94		20c. LOCATION — City or Town, State Brentwood, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Charles F. Bell				22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home 4739 Baltimore Avenue, Hyattsville, Md.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → PSEUDOBULBAR PALSY DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 8 YEARS							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO N.A.					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) N.A.		28b. TIME OF INJURY N.A. M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED N.A.		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) N.A.			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) N.A.					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Dennis J. Hand MD				29c. LICENSE NUMBER D04899		29d. DATE SIGNED (Month, Day, Year) 10/21/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DENNIS J. HAND MD 4600 CONNECTICUT AVE. N.W. WASH DC 20008							
31. DATE FILED (Month, Day, Year) OCT 25 1994				32. REGISTRAR'S SIGNATURE John Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33654

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) EMILY PATTIE ROOTS			2. DATE OF DEATH MONTH DAY YEAR OCT 22 1994		3. TIME OF DEATH 8:15 A
4. SOCIAL SECURITY NUMBER 577-24-3144	5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 79 YRS.	7. DATE OF BIRTH (Month, Day, Year) OCT. 8, 1915	8. BIRTHPLACE (State or Foreign Country) WASHINGTON, D.C.	
9a. FACILITY NAME (If not institution, give street and number) 2406 MUNCY CIRCLE (RESIDENCE)			9b. CITY, TOWN OR LOCATION OF DEATH LANDOVER		9c. COUNTY OF DEATH PRINCE GEORGE'S
10a. STATE MARYLAND			10b. COUNTY PRINCE GEORGE'S		10c. CITY, TOWN OR LOCATION LANDOVER
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
10e. STREET AND NUMBER 2406 MUNCY CIRCLE			10f. ZIP CODE 20785		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: BLACK					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) HOUSEWIFE		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE		17. KIND OF BUSINESS/INDUSTRY OWN HOME	
17. FATHER'S NAME (First, Middle, Last) WILLIAM HILL			18. MOTHER'S NAME (First, Middle, Maiden Surname) NENA BROWN		
19a. INFORMANT'S NAME (Type/Print) JAN WILLIAMS/GODSON			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2406 MUNCY CIRCLE LANDOVER, MARYLAND 20785		
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ARLINGTON NATIONAL CEM. 10-31 ARLINGTON, VIRGINIA		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Juanana L. Braxton			22. NAME AND ADDRESS OF FACILITY J.B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Coronary artery disease DUE TO (OR AS A CONSEQUENCE OF): Hypertensive arteriosclerotic cardiovascular disease DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST					Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER W. F. Valle M.D.			29c. LICENSE NUMBER D12879		29d. DATE SIGNED (Month, Day, Year) OCT 24, 1994
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) W. F. Valle M.D., 10701 TRAFLET DR., LARGO, MD 20772					
31. DATE FILED (Month, Day, Year) OCT 27 1994		32. REGISTRAR'S SIGNATURE Julia Davidson-Rendell			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. TO BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPT. OF HEALTH AND MENTAL HYGIENE PRIOR TO BURIAL, CREMATION, OR REMOVAL. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33655

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Raymond Roy Richardson				2. DATE OF DEATH MONTH DAY YEAR Oct. 28, 1994		3. TIME OF DEATH 2:18 A M	
4. SOCIAL SECURITY NUMBER 214-07-1699		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 83 YRS.	7. DATE OF BIRTH (Month, Day, Year) Sep 13, 1911		8. BIRTHPLACE (State or Foreign Country) MD	
9a. FACILITY NAME (If not institution, give street and number) 13120 Warrior Drive				9b. CITY, TOWN OR LOCATION OF DEATH Cresaptown		9c. COUNTY OF DEATH Allegany	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY Allegany		10c. CITY, TOWN OR LOCATION Cresaptown		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 13120 Warrior Drive				10f. ZIP CODE 21502		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Retired		16b. KIND OF BUSINESS/INDUSTRY National Jet Corp.			
17. FATHER'S NAME (First, Middle, Last) Jacob Richardson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Martha (Browning)			
19a. INFORMANT'S NAME (Type/Print) Phyllis Richardson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13120 Warrior Drive; Cresaptown, MD 21502			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hillcrest Burial Park 10/31		20c. LOCATION — City or Town, State Cumberland, MD 21502			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James F. Scarpelli</i>				22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cresaptown, MD 21502			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Chronic Renal Failure</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death <i>5 years</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Coronary Heart Failure; Itaconic</i>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Thomas E. Chappell</i>				29c. LICENSE NUMBER D35135		29d. DATE SIGNED (Month, Day, Year) 10/28/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Thomas E. Chappell; 912 Seton Drive; Cumberland, MD 21502							
31. DATE FILED (Month, Day, Year) NOV 02 1994		32. REGISTRAR'S SIGNATURE <i>Davidson-Robert</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit form. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) PETROVICH IGOR SOVERDA				2. DATE OF DEATH MONTH DAY YEAR OCTOBER 26, 1994		3. TIME OF DEATH HOURS MIN. 7:00 A M	
4. SOCIAL SECURITY NUMBER		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 23 YRS.	7. DATE OF BIRTH (Month, Day, Year) Dec 22, 1970		8. BIRTHPLACE (State or Foreign Country) Russia	
9a. FACILITY NAME (If not institution, give street and number) 4162 OCEAN GATEWAY				9b. CITY, TOWN OR LOCATION OF DEATH SALEM		9c. COUNTY OF DEATH DORCHESTER	
10a. STATE Maryland		10b. COUNTY Dorchester		10c. CITY, TOWN OR LOCATION Vienna		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 4160 Ocean Gateway				10f. ZIP CODE 21869		10g. CITIZEN OF WHAT COUNTRY? Russia	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5+		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Agricultural Student		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) Pyotr Pavlovich Soverda				18. MOTHER'S NAME (First, Middle, Maiden Surname) Tatyana Mikhailovna Krotkova			
19a. INFORMANT'S NAME (Type/Print) Tatyana & Pyotr Soverda				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Russia Moscow Region Mamontovka Gogolevskay St8/31			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Salisbury Crematory		DATE 11/4		20c. LOCATION — City or Town, State Salisbury, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Thomas Funeral Home 700 Locust Street Cambridge, Maryland 21613			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Shotgun wound of head DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO Partial	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input checked="" type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 10-25-94		28b. TIME OF INJURY 8:00 P M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED Subject shot		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) House		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 4162 Ocean Gateway			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) OCTOBER 27, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David R. Fowler 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) NOV 04 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

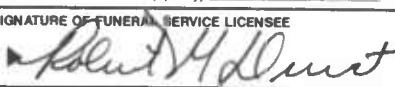
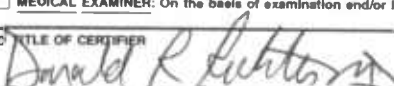
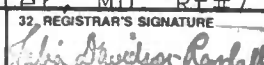
DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33657

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) EDWARD GEORGE SCHMIDT				2. DATE OF DEATH MONTH DAY YEAR OCTOBER 16, 1994		3. TIME OF DEATH 10:40 P M	
4. SOCIAL SECURITY NUMBER 217-30-1536		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 82 YRS.		7. DATE OF BIRTH (Month, Day, Year) AUG. 14, 1912	
9a. FACILITY NAME (If not institution, give street and number) DENNETT ROAD MANOR NURSING HOME				9b. CITY, TOWN OR LOCATION OF DEATH OAKLAND		9c. COUNTY OF DEATH GARRETT	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY GARRETT		10c. CITY, TOWN OR LOCATION DEER PARK		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER RT. 4 BOX 10				10f. ZIP CODE 21550		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) _____		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CABINET MAKER		16b. KIND OF BUSINESS/INDUSTRY CARPENTRY			
17. FATHER'S NAME (First, Middle, Last) CHARLES CARL SCHMIDT				18. MOTHER'S NAME (First, Middle, Maiden Surname) LUCINDA ELLEN BEEMAN			
19a. INFORMANT'S NAME (Type/Print) HARRIET DeBERRY				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) RT. 3 BOX 10130 DEER PARK, MD. 21550			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) OAKLAND CEMETERY		20c. LOCATION — City or Town, State 10/19 OAKLAND, MARYLAND		20d. DATE 10/19	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  MO0167				22. NAME AND ADDRESS OF FACILITY P.O. BOX 243 DURST FUNERAL HOME - OAKLAND, MD. 21550			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. Atherosclerotic cardiovascular disease b. Chronic renal failure c. _____ d. _____							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Organic Brain Syndrome							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D30035		29d. DATE SIGNED (Month, Day, Year) 10-17-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Donald R. Richter, MD Rt#7 Box1495 Oakland, MD 21550							
31. DATE FILED (Month, Day, Year) OCT 19 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33658

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) KEITH WILLARD STEYER				2. DATE OF DEATH MONTH DAY YEAR OCTOBER 16, 1994		3. TIME OF DEATH 3:10 A M	
4. SOCIAL SECURITY NUMBER 220-10-0852		5. SEX 1 M 2 F		6. AGE (In yrs. last birthday) 82 YRS.		7. DATE OF BIRTH (Month, Day, Year) JAN. 6, 1912	
9a. FACILITY NAME (If not institution, give street and number) GARRETT COUNTY MEMORIAL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH OAKLAND		9c. COUNTY OF DEATH GARRETT	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY GARRETT		10c. CITY, TOWN OR LOCATION OAKLAND		10d. INSIDE CITY LIMITS? 1 YES 2 NO	
10e. STREET AND NUMBER RT. 3 BOX 6440				10f. ZIP CODE 21550		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) FARMER		16b. KIND OF BUSINESS/INDUSTRY GENERAL FARMING			
17. FATHER'S NAME (First, Middle, Last) WILLIAM HARRISON STEYER				18. MOTHER'S NAME (First, Middle, Maiden Surname) ODESSA MYRTLE HARVEY			
19a. INFORMANT'S NAME (Type/Print) L. EVELYN STEYER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) RT. 3 BOX 6440 OAKLAND, MD. 21550			
20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of place, cemetery or other place) GARRETT MEMORIAL GARDENS 10/18		20c. LOCATION — City or Town, State OAKLAND, MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert H. Durst</i> M00167				22. NAME AND ADDRESS OF FACILITY P.O. BOX 243 DURST FUNERAL HOME - OAKLAND, MD 21550			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Shock Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST Ruptured Abdominal Aortic Aneurysm, 2 hrs ASHD						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)					
27. MANNER OF DEATH 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 YES 2 NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>C.W. Fedde MD</i>				29c. LICENSE NUMBER D22336		29d. DATE SIGNED (Month, Day, Year) 10-18-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) C.W. FEDDE, M.D. 311 N. FOURTH ST. OAKLAND, MD 21550							
31. DATE FILED (Month, Day, Year) OCT 19 1994				32. REGISTRAR'S SIGNATURE <i>Julia Brundage Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33659

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Diane M Studinary				2. DATE OF DEATH MONTH DAY YEAR Oct. 31, 1994		3. TIME OF DEATH 1045A M	
4. SOCIAL SECURITY NUMBER 196-54-2483		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 32 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan. 16, 1962 Pa.	
8a. FACILITY NAME (If not institution, give street and number) Washington County Hospital				8b. CITY, TOWN OR LOCATION OF DEATH Hagerstown		8c. COUNTY OF DEATH Washington	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Hagerstown		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 840 Georgia Ave.				10f. ZIP CODE 21740		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Computer Operator		16b. KIND OF BUSINESS/INDUSTRY Stationer			
17. FATHER'S NAME (First, Middle, Last) Edward Studiary				18. MOTHER'S NAME (First, Middle, Maiden Surname) Antoinette Kot			
19a. INFORMANT'S NAME (Type/Print) Jeffrey Canter				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 840 Georgia Ave. Hagerstown, Md. 21740			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. John's Cemetery		OATE 11/3		20c. LOCATION — City or Town, State Windber, Pa.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Edward C. Burner</i>				22. NAME AND ADDRESS OF FACILITY Burner Trade Services 1037 Dual Pl. Hagerstown, Md. 21740			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Metastatic Cervical Cancer</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. c. d. Approximate Interval Between Onset and Death 8 months							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Michael J. McCormack M.D.</i>				29c. LICENSE NUMBER 041667		29d. OATE SIGNED (Month, Day, Year) 11-1-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Michael J. McCormack M.D. 1795 Howell Rd. Hagerstown, MD 21740</i>							
31. OATE FILED (Month, Day, Year) NOV 02 1994				32. REGISTRAR'S SIGNATURE <i>Justinian</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Amended #1, 11/4/94, KW, Wash. Co.

94 33660

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) PAUL STENGER <i>Paul John Stenger</i>				2. DATE OF DEATH MONTH 11 DAY 02 YEAR 1994		3. TIME OF DEATH 9:44 p m			
4. SOCIAL SECURITY NUMBER 196-14-0725		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 76 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 3, 1918		8. BIRTHPLACE (State or Foreign Country) Pennsylvania	
9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY			9c. COUNTY OF DEATH Baltimore		
RESIDENCE OF DECEDENT				10a. STATE Maryland		10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Hagerstown	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 426 Jefferson Street		10f. ZIP CODE 21740		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W.W.II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) claims adjuster		16. KIND OF BUSINESS/INDUSTRY insurance					
17. FATHER'S NAME (First, Middle, Last) George Stenger				18. MOTHER'S NAME (First, Middle, Maiden Surname) Edith Kline					
19a. INFORMANT'S NAME (Type/Print) James F. Stenger				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3007 Leitersburg Pike, Waynesboro, Pa. 17268					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fairview Cemetery 11-5-94		20c. LOCATION — City or Town, State Mercersburg, Penna.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SEPSIS DUE TO (OR AS A CONSEQUENCE OF): b. CEREBROVASCULAR ACCIDENT DUE TO (OR AS A CONSEQUENCE OF): c. MITRAL VALVE INSUFFICIENCY DUE TO (OR AS A CONSEQUENCE OF): d. CORONARY ARTERY DISEASE Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Approximate Interval Between Onset and Death 10 WEEKS 4 MONTHS YEARS YEARS									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER P. CHEVRAY M.D., Ph.D.		29c. LICENSE NUMBER M1314		29d. DATE SIGNED (Month, Day, Year) 11/3/94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PIERRE CHEVRAY THE JOHNS HOPKINS HOSPITAL 601 N. BROADWAY BALTO. MD 21205									
31. DATE FILED (Month, Day, Year) NOV 04 1994				32. REGISTRAR'S SIGNATURE <i>John Benson Ford</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33661

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Arnell E. Streeter				2. DATE OF DEATH MONTH DAY YEAR October 21, 1994				3. TIME OF DEATH 12:20 P M			
4. SOCIAL SECURITY NUMBER 578-20-8887		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 80 YRS.	7. DATE OF BIRTH (Month, Day, Year) Aug. 3, 1914		8. BIRTHPLACE (State or Foreign Country) Arkansas					
9a. FACILITY NAME (If not institution, give street and number) 5024 Addison Road				9b. CITY, TOWN OR LOCATION OF DEATH Capitol Heights			9c. COUNTY OF DEATH Prince George's				
RESIDENCE OF DECEDENT											
10a. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Capitol Heights			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				
10e. STREET AND NUMBER 5024 Addison Road				10f. ZIP CODE 20743		10g. CITIZEN OF WHAT COUNTRY? United States					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Black				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Clerk			16b. KIND OF BUSINESS/INDUSTRY U. S. Treasury Dept.					
17. FATHER'S NAME (First, Middle, Last) James Walter Evans				18. MOTHER'S NAME (First, Middle, Maiden Surname) Leather Hughes							
19a. INFORMANT'S NAME (Type/Print) Dorothy Ann Phillips				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. Box 94, Morganza, MD 20660							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Cemetery		DATE 10-26		20c. LOCATION — City or Town, State Brentwood, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ellen H. Rapp				22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): b. Ischemic Endocarditis DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death 1 hr 10 years			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH X Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER		29c. LICENSE NUMBER D 16410		29d. DATE SIGNED (Month, Day, Year) Oct. 21, 1994					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Gabriel B. Jaffe, M. D., 7500 Hanover Parkway, #105, Greenbelt, MD 20770											
31. DATE FILED (Month, Day, Year) OCT 24 1994		32. REGISTRAR'S SIGNATURE Julia Davidson-Randall									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 6 and 7 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED

LIBRARY

5

94 33662

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mary Gill Smith				2. DATE OF DEATH MONTH DAY YEAR October 23, 1994				3. TIME OF DEATH 2:00 AM	
4. SOCIAL SECURITY NUMBER 240-28-3810		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		7. DATE OF BIRTH (Month, Day, Year) 1922		8. BIRTHPLACE (State or Foreign Country) North Carolina	
9a. FACILITY NAME (If not institution, give street and number) 6911 17th Avenue				9b. CITY, TOWN OR LOCATION OF DEATH Hyattsville				9c. COUNTY OF DEATH Prince Georges	
RESIDENCE OF DECEDENT									
10a. STATE MARYLAND		10b. COUNTY PRINCE GEORGES		10c. CITY, TOWN OR LOCATION HYATTSVILLE				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 6911 17th Avenue				10f. ZIP CODE 20783		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: WHITE		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER		16b. KIND OF BUSINESS/INDUSTRY OWN HOME					
17. FATHER'S NAME (First, Middle, Last) JOHN M. GILL				18. MOTHER'S NAME (First, Middle, Maiden Surname) GRACE SIMERSON					
19a. INFORMANT'S NAME (Type/Print) RAYMOND SMITH				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6911 17th AVENUE, HYATTSVILLE, MARYLAND 20783					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GEORGE WASHINGTON CEMETERY			20c. LOCATION — City or Town, State ADELPHI, MARYLAND		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Timothy A. Campbell</i>				22. NAME AND ADDRESS OF FACILITY FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W., SIL. SP., MD 20901					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cerebral aneurysm</i> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death 20 months	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Harold A. Davidson</i>				29c. LICENSE NUMBER D20352		29d. DATE SIGNED (Month, Day, Year) 10/25/94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HARVEY R. A. TERRY MD 8926 Woodward Rd Clarks MD									
31. DATE FILED (Month, Day, Year) OCT 26 1994				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33663

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LILLIAN SMULKIN				2. DATE OF DEATH MONTH 10 DAY 23 YEAR 94		3. TIME OF DEATH 1:37 P M	
4. SOCIAL SECURITY NUMBER 577-90-7180		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 81 YRS.	IF UNDER 1 YEAR MONTHS _____ DAYS _____	IF UNDER 24 HRS. HOURS _____ MIN. _____	7. DATE OF BIRTH (Month, Day, Year) FEB. 1, 1913	
8. BIRTHPLACE (State or Foreign Country) MARYLAND							
9a. FACILITY NAME (If not institution, give street and number) HEBREW HOME OF GREATER WASHINGTON				9b. CITY, TOWN OR LOCATION OF DEATH ROCKVILLE		9c. COUNTY OF DEATH MONTGOMERY	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY MONTGOMERY		10c. CITY, TOWN OR LOCATION ROCKVILLE		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 6121 MONTROSE ROAD				10f. ZIP CODE 20852		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) _____		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE		16b. KIND OF BUSINESS/INDUSTRY OWN HOME			
17. FATHER'S NAME (First, Middle, Last) SAM DEARING				18. MOTHER'S NAME (First, Middle, Maiden Surname) BERTHA (UNKNOWN)			
19a. INFORMANT'S NAME (Type/Print) HEBREW HOME SOCIAL SERVICES				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6121 MONTROSE ROAD - ROCKVILLE, MD. 20852			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) KING DAVID MEMORIAL GARDEN 10/26		20c. LOCATION — City or Town, State FALLS CHURCH, VA.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Frank A. Stone</i>				22. NAME AND ADDRESS OF FACILITY DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE - ROCKVILLE, MD. 20852			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MYELODYSPASTIC SYNDROME DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____							Approximate Interval Between Onset and Death YEARS
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. SCHIZOPHRENIA DEMENTIA							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. PLACE OF DEATH (Check only one) OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER P. Talwar, M.D.			
29c. LICENSE NUMBER D 36552				29d. DATE SIGNED (Month, Day, Year) 10/24/94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) P. TALWAR, 6121 MONTROSE ROAD, ROCKVILLE MD. 20852							
31. DATE FILED (Month, Day, Year) OCT 27 1994				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33664

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Mrs. Segal</u>				2. DATE OF DEATH MONTH DAY YEAR <u>OCTOBER 20 1994</u>				3. TIME OF DEATH <u>12:35 P</u>									
4. SOCIAL SECURITY NUMBER <u>216-64-2386</u>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (in yrs. last birthday) <u>41</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) <u>8-14-53</u>		8. BIRTHPLACE (State or Foreign Country) <u>Washington D.C.</u>					
9a. FACILITY NAME (If not institution, give street and number) <u>Laurel Regional Hospital</u>						9b. CITY, TOWN OR LOCATION OF DEATH <u>Laurel</u>				9c. COUNTY OF DEATH <u>Prince George</u>							
10a. STATE <u>Maryland</u>				10b. COUNTY <u>Montgomery</u>				10c. CITY, TOWN OR LOCATION <u>Silver Spring</u>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
10e. STREET AND NUMBER <u>1453 Silo Way</u>						10f. ZIP CODE <u>20905</u>				10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>2</u> College (1-4 or 5+) <u>2</u>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Parts Manager</u>				16b. KIND OF BUSINESS/INDUSTRY <u>Automobile</u>									
17. FATHER'S NAME (First, Middle, Last) <u>Sanford Jean Segal</u>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Evelyn Bogrovitz Steinberg</u>											
19a. INFORMANT'S NAME (Type/Print) <u>Lisa Segal</u>						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1453 Silo Way, Silver Spring, MD 20905</u>											
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Judean Memorial Gardens 10/21</u>				20c. LOCATION — City or Town, State <u>Olney, MD</u>									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>[Signature]</u>						22. NAME AND ADDRESS OF FACILITY <u>Edward Sagel Funeral Direction</u> <u>1091 Rockville Pike, Rockville MD 20852</u>											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Pancreatic Cancer</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.												Approximate Interval Between Onset and Death <u>10 mo.</u>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED							
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)													
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												29b. SIGNATURE AND TITLE OF CERTIFIER <u>[Signature]</u>		29c. LICENSE NUMBER <u>033686</u>		29d. DATE SIGNED (Month, Day, Year) <u>10/20/94</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 21) (Type, Print) <u>Yvonne Miller, MD 18111 Prince Philip Dr. Olney, MD 20852</u>																	
31. DATE FILED (Month, Day, Year) <u>OCT 27 1994</u>				32. REGISTRAR'S SIGNATURE <u>[Signature]</u>													

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit form.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33665

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ALFRED BOYNTON STEVENSON				2. DATE OF DEATH MONTH DAY YEAR October 18, 1994		3. TIME OF DEATH 7:40 P M	
4. SOCIAL SECURITY NUMBER 456-20-3402		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 75 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 15, 1919	
8. FACILITY NAME (If not institution, give street and number) 415 Russell Avenue, Apt. # 302				9b. CITY, TOWN OR LOCATION OF DEATH Gaithersburg		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Gaithersburg		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 415 Russell Avenue, Apt. # 302				10f. ZIP CODE 20877		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 6		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Cryptologic Linguist		16b. KIND OF BUSINESS/INDUSTRY National Security Agency			
17. FATHER'S NAME (First, Middle, Last) Rev. Robert Emory Stevenson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ada Ross			
19a. INFORMANT'S NAME (Type/Print) Rue Burke Stevenson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 415 Russell Avenue, Apt. # 302, Gaithersburg, MD 20877			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Geo. Wash. University Medical Center		20c. DATE 10/18/1994		20d. LOCATION — City or Town, State Washington, D.C.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Columbia Mortuary Services, Inc. 225 Missouri Ave. Washington, D.C. 20011			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic pancreatic cancer DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death ~3 mo.
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Dying Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) Hospice pt.					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>George A. Sotos</i>				29c. LICENSE NUMBER MD D43083		29d. DATE SIGNED (Month, Day, Year) 10/19/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 14800 Physician Ln Suite 212 Rockville Md 20850							
31. DATE FILED (Month, Day, Year) OCT 27 1994		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33666

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) DANIEL M. SHAY				2. DATE OF DEATH OCTOBER 26, 1994		3. TIME OF DEATH 2:12 A M	
4. SOCIAL SECURITY NUMBER 233-64-6605		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 52 YRS.		7. DATE OF BIRTH (Month, Day, Year) MAY 10, 1942	
8. BIRTHPLACE (State or Foreign Country) OHIO				9a. FACILITY NAME (If not institution, give street and number) MONTGOMERY GENERAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH OLNEY	
9c. COUNTY OF DEATH MONTGOMERY				10a. STATE MARYLAND		10b. COUNTY MONTGOMERY	
10c. CITY, TOWN OR LOCATION LAYTONSVILLE				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 5808 RIGGS ROAD	
10f. ZIP CODE 20882				10g. CITIZEN OF WHAT COUNTRY? UNITED STATES		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) OWNER - OPERATOR		16b. KIND OF BUSINESS/INDUSTRY AIR CONDITION - HEATING	
17. FATHER'S NAME (First, Middle, Last) PAUL M SHAY				18. MOTHER'S NAME (First, Middle, Last) LUCILLE MEES			
19a. INFORMANT'S NAME (Type/Print) DANIEL P. SHAY				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18605 MINCASTER ROAD DERWOOD, MD. 20855			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) RESURRECTION CEMETERY		20c. LOCATION — City or Town, State 10/29 CLINTON, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Muriel H. Barber</i>				22. NAME AND ADDRESS OF FACILITY MURIEL H. BARBER FUNERAL HOME 20882 P.O. BOX 5038 LAYTONSVILLE, MARYLAND			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Sudden Death 2 to Massive Aortic M.I.</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Hypertensive Arteriosclerotic C.V. Disease</i> DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST				Approximate Interval Between Onset and Death <i>minutes</i> <i>years</i>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Excessive Tobacco Use</i>				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>James M. Bacos PA</i>		29c. LICENSE NUMBER D05893	
29d. DATE SIGNED (Month, Day, Year) Oct 26, 1994				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. JAMES M. BACOS 18111 PRINCE PHILIP DRIVE OLNEY, MARYLAND 20832			
31. DATE FILED (Month, Day, Year) OCT 28 1994				32. REGISTRAR'S SIGNATURE <i>Lila Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit and be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

24

94 33667

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) William F. Smith				2. DATE OF DEATH MONTH DAY YEAR October 26, 1994		3. TIME OF DEATH 6:55 a.m.	
4. SOCIAL SECURITY NUMBER 219-12-4222		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 70 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 5, 1924	
9a. FACILITY NAME (If not institution, give street and number) 11617 Old Baltimore Pike				9b. CITY, TOWN OR LOCATION OF DEATH Beltsville		9c. COUNTY OF DEATH Prince Georges	
10a. STATE Maryland		10b. COUNTY Prince Georges		10c. CITY, TOWN OR LOCATION Beltsville		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 11617 Old Baltimore Pike,				10f. ZIP CODE 20705		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Mail Clerk		16b. KIND OF BUSINESS/INDUSTRY U.S. Post Office			
17. FATHER'S NAME (First, Middle, Last) James A. Smith				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah E. Lancaster			
19a. INFORMANT'S NAME (Type/Print) (Daughter) Mrs Joan Griffin				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) #6 Garrett Ave, Baltimore, Md 21227			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Queen's Chapel Cem. 10/31		20c. LOCATION — City or Town, State Beltsville, Md			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George R. Snowden</i>				22. NAME AND ADDRESS OF FACILITY Snowden Funeral Home P.A. 20850 246 N. Washington St, Rockville, Md			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Metastatic Carcinoma</i> DUE TO (OR AS A CONSEQUENCE OF): a. _____ b. _____ c. _____ d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST e. _____ f. _____ g. _____ h. _____							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>William A. Warren</i>				29c. LICENSE NUMBER D13916		29d. DATE SIGNED (Month, Day, Year) 10/27/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>William A. Warren 321 Prince George St Laurel, Md</i>							
31. DATE FILED (Month, Day, Year) OCT 28 1994				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33668

Amended # 8, 10/25/94 MRT Montgomery County
 1 - FOR STATE REGISTRAR
 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH
 REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ELIZABETH A. STORM				2. DATE OF DEATH OCTOBER 24, 1994		3. TIME OF DEATH 2:30 A M	
4. SOCIAL SECURITY NUMBER 219-1 0-2835		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 96 YRS.		7. DATE OF BIRTH (Month, Day, Year) DECEMBER 6, 1897	
8. BIRTHPLACE (State or Foreign Country) MISSISSIPPI				9. COUNTY OF DEATH MONTGOMERY			
9a. FACILITY NAME (If not institution, give street and number) WILSON HEALTH CARE				9b. CITY, TOWN OR LOCATION OF DEATH GAITHERSBURG		9c. COUNTY OF DEATH MONTGOMERY	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY MONTGOMERY		10c. CITY, TOWN OR LOCATION GAITHERSBURG		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 301 RUSSELL AVENUE				10f. ZIP CODE 20877		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 6				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) TEACHER		16b. KIND OF BUSINESS/INDUSTRY EDUCATION	
17. FATHER'S NAME (First, Middle, Last) ADEN C. STORM				18. MOTHER'S NAME (First, Middle, Maiden Surname) ELIZABETH BERGMANN			
19a. INFORMANT'S NAME (Type/Print) CAROL B. STORM				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 407 RUSSELL AVENUE GAITHERSBURG, MD. 20877			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DRUID RIDGE CEMETERY		DATE 10/27		20c. LOCATION — City or Town, State BALTIMORE, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Muriel H. Barber</i>				22. NAME AND ADDRESS OF FACILITY MURIEL H. BARBER FUNERAL HOME 20882 P.O. BOX 5038 LAYTONSVILLE, MARYLAND			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
a. <i>aspiration pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF):							4d.
b. <i>cardiovascular accident</i> DUE TO (OR AS A CONSEQUENCE OF):							1 mo
c. <i>congestive heart failure</i> DUE TO (OR AS A CONSEQUENCE OF):							years
d. <i>hypertension</i> DUE TO (OR AS A CONSEQUENCE OF):							years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John R. Melnick MD</i>				29c. LICENSE NUMBER D19294		29d. DATE SIGNED (Month, Day, Year) 10/24/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John R. Melnick - 911 Russell Ave Gaithersburg Md 20879							
31. DATE FILED (Month, Day, Year) OCT 25 1994				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 may be retained by the funeral director, page 5 should be detached for use as the burial-transit permit. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

17

RECEIVED

RECEIVED

RECEIVED

94 33669

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Bernice F. Sacks				2. DATE OF DEATH MONTH DAY YEAR October 22, 1994				3. TIME OF DEATH 9:50 P M			
4. SOCIAL SECURITY NUMBER 267-30-5337		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 81 YRS.		7. DATE OF BIRTH (Month, Day, Year) November 23, 1912		8. BIRTHPLACE (State or Foreign Country) New York			
9a. FACILITY NAME (If not institution, give street and number) Collingswood Nursing Center				9b. CITY, TOWN OR LOCATION OF DEATH Rockville				9c. COUNTY OF DEATH Montgomery			
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 2201 Colston Drive, #509A				10f. ZIP CODE 20910		10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Accountant		16b. KIND OF BUSINESS/INDUSTRY							
17. FATHER'S NAME (First, Middle, Last) William Fried				18. MOTHER'S NAME (First, Middle, Maiden Surname) Tina Fox							
19a. INFORMANT'S NAME (Type/Print) William M. Sacks				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 512 Carr Avenue, Rockville, Maryland 20850							
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 10/24/94		20c. DATE 10/24/94		20d. LOCATION — City or Town, State Alexandria, Virginia					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Timothy A. Campbell				22. NAME AND ADDRESS OF FACILITY FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W., SIL. SP., MD 20901							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death Days			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pulmonary Hypertension, Dementia, Mitral Regurgitation, COPD DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]				29c. LICENSE NUMBER D34590		29d. DATE SIGNED (Month, Day, Year) 10/24/94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 10810 Connecticut Ave Kensington, MD 20895											
31. DATE FILED (Month, Day, Year) OCT 25 1994				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Amended # 17 10/25/94 MRT Montgomery Cty. 94 33670

FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) Barbara Anne Swartzak		2. DATE OF DEATH MONTH DAY YEAR October 21, 1994		3. TIME OF DEATH 3:18 A.M.	
4. SOCIAL SECURITY NUMBER 306-32-9872		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 62 YRS.	
7. DATE OF BIRTH (Month, Day, Year) 1931		8. BIRTHPLACE (State or Foreign Country) Illinois		9. COUNTY OF DEATH Montgomery	
9a. FACILITY NAME (If not institution, give street and number) Montgomery General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Olney		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Rockville	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 16000 Sycamore Lane		10f. ZIP CODE 20853	
10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Bus Driver		16b. KIND OF BUSINESS/INDUSTRY County Government		17. FATHER'S NAME (First, Middle, Last) George Emil Schecidau — Schneidau	
18. MOTHER'S NAME (First, Middle, Maiden Surname) Agnes Hudecek		19a. INFORMANT'S NAME (Type/Print) Janet Ann Rowe		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17614 Longview Lane Olney, Maryland 20832	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 10/25/94		20c. LOCATION — City or Town, State Silver Spring, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Timothy J. Campbell		22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901		23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. STROKE b. Myocardial Infarction c. Seizure Disorders d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		25. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURRED 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Gauranah THAKER		29c. LICENSE NUMBER D43430	
29d. DATE SIGNED (Month, Day, Year) 10/21/94		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 18111 Prince Philip Dr #212 Olney MD 20832		31. DATE FILED (Month, Day, Year) OCT 25 1994	
32. REGISTRAR'S SIGNATURE Julia Davidson-Rendell					

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33671

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Edward Kenneth Sweeney				2. DATE OF DEATH MONTH DAY YEAR October 18, 1994		3. TIME OF DEATH 2130 M	
4. SOCIAL SECURITY NUMBER 577-12-0522		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		8. AGE (In yrs. last birthday) 80 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 18, 1914	
9a. FACILITY NAME (If not institution, give street and number) Frederick Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Frederick		9c. COUNTY OF DEATH Frederick	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Boys		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 16910 Barnesville Road				10f. ZIP CODE 20841		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMY FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) — College (1-4 or 5+) 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Chief		16b. KIND OF BUSINESS/INDUSTRY DC Fire Department			
17. FATHER'S NAME (First, Middle, Last) Edward A. Sweeney				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Broderick			
19a. INFORMANT'S NAME (Type/Print) Vivian S. Sweeney				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16910 Barnesville Road, Boys, Maryland 20841			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc. 10/21/94		20c. LOCATION — City or Town, State Bethesda, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael P. Kutta</i> M00348				22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Rockville, Inc., 300 W. Montgomery Ave Rockville, Maryland 20850-2805			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>bilobar pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <i>Alzheimers dementia</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>Urinary tract infection/sepsis</i> DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Susan Brinkley</i>				29c. LICENSE NUMBER D43389		29d. DATE SIGNED (Month, Day, Year) October 20, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Susan Brinkley, M.D., 915 Tollhouse Avenue, #203, Frederick, MD 21701							
31. DATE FILED (Month, Day, Year) OCT 24 1994				32. REGISTRAR'S SIGNATURE <i>Juha Davidson-Rendell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

94 33672

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Dorothy A. Schmid				2. DATE OF DEATH MONTH DAY YEAR October 22, 1994				3. TIME OF DEATH 6:15 P M							
4. SOCIAL SECURITY NUMBER 216-64-4031		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 90 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Jan. 31, 1904		8. BIRTHPLACE (State or Foreign Country) Washington, D.C.			
9a. FACILITY NAME (If not institution, give street and number) Manor Care-Wheaton						9b. CITY, TOWN OR LOCATION OF DEATH Wheaton				9c. COUNTY OF DEATH Montgomery					
RESIDENCE OF DECEDENT															
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Bethesda				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 9415 Rockville Pike						10f. ZIP CODE 20814				10g. CITIZEN OF WHAT COUNTRY? United States					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker				16b. KIND OF BUSINESS/INDUSTRY Own Home							
17. FATHER'S NAME (First, Middle, Last) John Anderson						18. MOTHER'S NAME (First, Middle, Maiden Surname) Amy McCormick									
19a. INFORMANT'S NAME (Type/Print) Suzanne W. Athanas						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9415 Rockville Pike, Bethesda, Maryland 20814									
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc. 10/25/94				20c. LOCATION — City or Town, State Bethesda, Maryland							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael E. Higin</i> M00846						22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>respiratory failure</i> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST												Approximate Interval Between Onset and Death 18 hours			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>generalized arteriosclerosis with cerebral arteriosclerosis, atherosclerotic heart disease</i>												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Wilfred R. Elyman</i> MD				29c. LICENSE NUMBER D-00946 MD		29d. DATE SIGNED (Month, Day, Year) 10/23/94					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Wilfred R. Elyman MD, 1125 Rockville Pike Rockville Md 20852															
31. DATE FILED (Month, Day, Year) OCT 24 1994				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>											

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33673

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Lillian Day Swenarton				2. DATE OF DEATH MONTH DAY YEAR October 24, 1994		3. TIME OF DEATH 6:00 P M	
4. SOCIAL SECURITY NUMBER 077-03-5882		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 78 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) April 5, 1916	
9a. FACILITY NAME (If not institution, give street and number) Carriage Hill Nursing Center				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 3721 Kayson Street				10f. ZIP CODE 20906		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5 +)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Administrator		16b. KIND OF BUSINESS/INDUSTRY Education			
17. FATHER'S NAME (First, Middle, Last) Harry Day				18. MOTHER'S NAME (First, Middle, Maiden Surname) Miranda (Unavailable)			
19a. INFORMANT'S NAME (Type/Print) Robert O. Swenarton				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as 10			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Suburban Crematory		OATE 10-26		20c. LOCATION — City or Town, State Silver Spring, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ellen H. Rapp				22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Chronic obstructive pulmonary disease DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death 2 yrs
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. None							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER George Kenton, MD				29c. LICENSE NUMBER D08695		29d. DATE SIGNED (Month, Day, Year) October 25, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) George S. Kenton, M. D., 10620 Georgia Avenue, #213, Silver Spring, MD 20902							
31. DATE FILED (Month, Day, Year) OCT 25 1994				32. REGISTRAR'S SIGNATURE Julia Davidson-Randell			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. TO BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPT. OF HEALTH AND MENTAL HYGIENE PRIOR TO BURIAL, CREMATION, OR REMOVAL. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33674

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Irene Loretta Scaggs				2. DATE OF DEATH MONTH October DAY 25 YEAR 1994		3. TIME OF DEATH 1430 pm M	
4. SOCIAL SECURITY NUMBER 219 12 4899		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 80 YRS.		7. DATE OF BIRTH (Month, Day, Year) 8-3-1914	
9a. FACILITY NAME (If not institution, give street and number) Calvert Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Prince Frederick		9c. COUNTY OF DEATH Calvert	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY Calvert		10c. CITY, TOWN OR LOCATION Owings		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 5965 Scaggs Rd.				10f. ZIP CODE 20736		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		15b. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housekeeping		16b. KIND OF BUSINESS/INDUSTRY Hospital/Health Care			
17. FATHER'S NAME (First, Middle, Last) George W. S. Scaggs				18. MOTHER'S NAME (First, Middle, Maiden Surname) Carrie Mable Norton			
19a. INFORMANT'S NAME (Type/Print) Helen M. Ogle				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3707 Crystal Ln., Temple Hills, MD 20748			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lower Marlboro UMC Cem. 10-28-94 Owings, (Cal) MD		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>M. Michael Phelan</i>				22. NAME AND ADDRESS OF FACILITY Rausch Funeral Home, PA Owings, MD 20736			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pneumonia / Acute Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF): Chronic Obstructive Pulmonary Disease DUE TO (OR AS A CONSEQUENCE OF): Congestive Heart Failure / Cardiomyopathy DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death Days Years Months							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Osteoporosis Vertebral Fractures Asthma							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Gerald P. Sterner MD				29c. LICENSE NUMBER D17245		29d. DATE SIGNED (Month, Day, Year) Oct. 25, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. GERALD STERNER, M.D. PRINCE FREDERICK, MD. 20678							
31. DATE FILED (Month, Day, Year) OCT 28 1994		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33675

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Heath Warren Steele</i>				2. DATE OF DEATH MONTH <i>10</i> DAY <i>26</i> YEAR <i>94</i>		3. TIME OF DEATH <i>1307</i> M	
4. SOCIAL SECURITY NUMBER <i>220-30-4824</i>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>74</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>1-02-20</i>	
8. BIRTHPLACE (State or Foreign Country) <i>New York</i>				9a. FACILITY NAME (If not institution, give street and number) <i>Union Hospital</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Elkton</i>	
9c. COUNTY OF DEATH <i>Cecil</i>				10a. STATE <i>Maryland</i>		10b. COUNTY <i>Cecil</i>	
10c. CITY, TOWN OR LOCATION <i>Chesapeake City</i>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <i>106 Woodstock Drive</i>	
10f. ZIP CODE <i>21915</i>				10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>WW 2</i>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>Elementary/Secondary (0-12) 12</i>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Salesman</i>		15b. KIND OF BUSINESS/INDUSTRY <i>Printing</i>			
16. DECEDENT'S NAME (First, Middle, Last) <i>Heath McClung Steele</i>				16. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Florence Truman</i>			
17. INFORMANT'S NAME (Type/Print) <i>Frances Thompson Steele</i>				18. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>106 Woodstock Drive, Chesapeake City, Md. 21915</i>			
19a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		19b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>R. A. Ferris & Co.,</i>		19c. DATE <i>21915</i>		19d. LOCATION — City or Town, State <i>West Chester, Pa.</i>	
20. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				21. NAME AND ADDRESS OF FACILITY <i>259 E. Main St., Gee Funeral Home Elkton, Md. 21921</i>			
22. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Massive exsanguination into the lung/apoplexy</i> DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. <i>COPD / Cor pulmonale</i> DUE TO (OR AS A CONSEQUENCE OF):					
		c. _____ DUE TO (OR AS A CONSEQUENCE OF):					
		d. _____ DUE TO (OR AS A CONSEQUENCE OF):					
23. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>ASCVD / NBP / BPH</i> <i>Dysenteritis with microperforations, parotitis, abscess and sepsis</i>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <i>D30291</i>		29d. DATE SIGNED (Month, Day, Year) <i>10/27/94</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Robert Demetria M.D. 111 W. High St Elkton, Md 21921</i>							
31. DATE FILED (Month, Day, Year) <i>OCT 28 '94</i>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 may be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33676

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Ethel L. Shanahan				2. DATE OF DEATH MONTH DAY YEAR October 27, 1994		3. TIME OF DEATH 0450 M	
4. SOCIAL SECURITY NUMBER 222-03-3352		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 76 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec. 24, 1917	
9a. FACILITY NAME (If not institution, give street and number) Laurelwood Nursing Center				9b. CITY, TOWN OR LOCATION OF DEATH Elkton		8. BIRTHPLACE (State or Foreign Country) Delaware	
10a. STATE Maryland				10b. COUNTY Cecil		9c. COUNTY OF DEATH Cecil	
10c. CITY, TOWN OR LOCATION Elkton				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 256 West Main Street				10f. ZIP CODE 21921		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Waitress		16b. KIND OF BUSINESS/INDUSTRY Food Service			
17. FATHER'S NAME (First, Middle, Last) Pehr Lundberg				18. MOTHER'S NAME (First, Middle, Maiden Surname) Esther Berg			
19a. INFORMANT'S NAME (Type/Print) Con F. Shanahan				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 120 Beauchamp Road - Elkton, MD 21921			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) R.A. Ferris & Company		20c. LOCATION — City or Town, State 10-28 1994 West Chester, PA			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donna S. Hicks</i>				22. NAME AND ADDRESS OF FACILITY Hicks Home for Funerals, P.A. 103 West Stockton Street Elkton, MD 21921-5521			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Squamous cell carcinoma of lung with metastasis to bone and mediastinum Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>William F. Renzulli M.D.</i>		29c. LICENSE NUMBER D44102		29d. DATE SIGNED (Month, Day, Year) 10/27/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) William F. Renzulli, M.D. - 901 Warburton Road - Elkton, MD 21921							
31. DATE FILED (Month, Day, Year) OCT 28 '94		32. REGISTRAR'S SIGNATURE <i>Lisa Davidson-Rendell</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Amended # 10b, 10c, 10f, 10/31/94 Jan Cecil Co. 94 33677

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ANNA STRANAHAN				2. DATE OF DEATH MONTH Oct DAY 24 YEAR 1994		3. TIME OF DEATH 8:45 pm	
4. SOCIAL SECURITY NUMBER 195-05-4917		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 82 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct 16 1912	
8. BIRTHPLACE (State or Foreign Country) MD				9a. FACILITY NAME (If not institution, give street and number) Saint Joseph Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Towson, Maryland	
9c. COUNTY OF DEATH Baltimore				10a. STATE MD			
10b. COUNTY Baltimore City				10c. CITY, TOWN OR LOCATION Baltimore City, Towson, MD			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 3007 White Ave.,			
10f. ZIP CODE Unknown-21214				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Labor		16b. KIND OF BUSINESS/INDUSTRY Clothing manufacturer	
17. FATHER'S NAME (First, Middle, Last) John Stranahan				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ida Harvey			
19a. INFORMANT'S NAME (Type/Print) Edward Kanaskie				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2710 Forwood St Chester PA 19013			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lawn Croft Cemetery 10-28-1994		20c. LOCATION — City or Town, State Linwood, PA		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Richard L. Groffie</i>	
22. NAME AND ADDRESS OF FACILITY R T Foard Funeral Home 111 S Queen St Rising Sun, MD 21911		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METASTATIC LEIOMYOSARCOMA OF UTERUS DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 1 WEEK					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ACUTE RENAL FAILURE DEHYDRATION DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
26. PLACE OF DEATH (Check only one) <input checked="" type="checkbox"/> HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Sumner P Mehta MD</i>				29c. LICENSE NUMBER D41410		29d. DATE SIGNED (Month, Day, Year) 10-25-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOGINDER P. MEHTA, MD, ST. JOSEPH MEDICAL CENTER, 7620 YORK ROAD, TOWSON, MD							
31. DATE FILED (Month, Day, Year) OCT 26 '94				32. REGISTRAR'S SIGNATURE <i>Jake Davidson-Rendell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21206
 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital for use in the medical record. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94-6386-510

B.K.S

ITEMS: 27,28a,b,d, PER MEO FILM G-718 12/5/94 t.t.

94 33678

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) STEVEN T. STANCLIFF				2. DATE OF DEATH MONTH DAY YEAR NOV. 04 94		3. TIME OF DEATH 1508 P M	
4. SOCIAL SECURITY NUMBER 194-58-5291		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 21 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 22 1973	
9a. FACILITY NAME (If not institution, give street and number) 1511 GUILFORD AVENUE				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH BALTIMORE	
10a. STATE PA		10b. COUNTY Lancaster		10c. CITY, TOWN OR LOCATION Paradise		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 49 Paradise Lane				10f. ZIP CODE 17562		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 1 College (1-4 or 5+) 1		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Production Artist		16b. KIND OF BUSINESS/INDUSTRY Art			
17. FATHER'S NAME (First, Middle, Last) Andrew D. Stancliff				18. MOTHER'S NAME (First, Middle, Maiden Surname) Earline Earhart			
19a. INFORMANT'S NAME (Type/Print) Earline E. Oberholtzer				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 49 Paradise Lane Paradise, PA 17562			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Calvary Monument Cem. 11-9-1994		20c. LOCATION — City or Town, State Paradise, PA			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Thomas J. Skanda Jr.</i>				22. NAME AND ADDRESS OF FACILITY SKANDA FH BALTE, MD- 21224 2829 HUDSON ST.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple Injuries DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) BUILDING					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY FOUND 11-4-94 10-29-94		28b. TIME OF INJURY 2:00 PM		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED subject precipitated off roof		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) building			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 1511 Guilford Ave Baltimore City, Md					
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Samuel J. Christman</i>				29c. LICENSE NUMBER O.C.M.E		29d. DATE SIGNED (Month, Day, Year) NOV. 5, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) NOV 14 1994		REGISTRAR'S SIGNATURE <i>Julia Hudson-Hall</i>					

DIVISION OF VITAL RECORDS, P.O. BOX 68760
 BALTIMORE, MARYLAND 21215-0022
 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33679

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Walburga M. Schieber				2. DATE OF DEATH MONTH DAY YEAR Oct. 26 1994		3. TIME OF DEATH 3:30 PM	
4. SOCIAL SECURITY NUMBER 092 22 8706		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (in yrs. last birthday) 90 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec. 13 1903	
9a. FACILITY NAME (If not institution, give street and number) Villa Rosa Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Mitchellville		9c. COUNTY OF DEATH Prince George's	
10a. STATE Maryland				10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Bowie	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 12112 Linden Lane			
10f. ZIP CODE 20715				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES No		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: No		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Franz Mattmann				18. MOTHER'S NAME (First, Middle, Maiden Surname) Barbara Wirsching			
19a. INFORMANT'S NAME (Type/Print) Irmengarde S. Buehler				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12112 Linden Lane Bowie Maryland 20715			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Charles Cemetery		20c. LOCATION — City or Town, State Pinelawn New York		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert E. Evans Pres.				22. NAME AND ADDRESS OF FACILITY Beall-Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Md. 20715			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. End stage Neurodegenerative disease DUE TO (OR AS A CONSEQUENCE OF): b. Sepsis DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death 1-2 year 2 day
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Roitan Fardian				29c. LICENSE NUMBER D4 3446		29d. DATE SIGNED (Month, Day, Year) 10/26/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ROITAN FARAH-FAR, M.D. 4000 Mitchellville road B216 Bowie MD 20716							
31. DATE FILED (Month, Day, Year) OCT 28 1994				32. REGISTRAR'S SIGNATURE J. Gordon Fardian			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2. 1912 -
End stage Neurodegenerative

1
1

"Vile"
H 3116

94 33680

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Dennis Spence				2. DATE OF DEATH MONTH DAY YEAR Oct. 18 1994		3. TIME OF DEATH 11:15 P M	
4. SOCIAL SECURITY NUMBER 041-46-0699		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 57 YRS.		7. DATE OF BIRTH (Month, Day, Year) 7-27-37	
9a. FACILITY NAME (If not institution, give street and number) 5805 Old Temple Hills Road				9b. CITY, TOWN OR LOCATION OF DEATH Temple Hills		9c. COUNTY OF DEATH P.G.	
10a. STATE MD.				10b. COUNTY P.G.		10c. CITY, TOWN OR LOCATION Temple Hills	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 5805- Old Temple Hills Road			
10f. ZIP CODE 20748				10g. CITIZEN OF WHAT COUNTRY? Jamaica			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Cement Finisher		16b. KIND OF BUSINESS/INDUSTRY N/A			
17. FATHER'S NAME (First, Middle, Last) Berisford Fraser				18. MOTHER'S NAME (First, Middle, Maiden Surname) Miriam Stence			
19a. INFORMANT'S NAME (Type/Print) Alfie Fraser				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5805 Old Temple Hills Rd., Temple Hills, Md. 20748			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Northern Virginia Crem		DATE 10/19		20c. LOCATION — City or Town, State Arl., Va.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Shelton W. Hackett</i>				22. NAME AND ADDRESS OF FACILITY Hackett's Funeral Chapel, Inc. 814- Upshur Street, N.W.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Esophageal Cancer DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate interval Between Onset and Death 1 year
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hepatic Metastasis							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Henry Hackett</i>				29c. LICENSE NUMBER D20352		29d. DATE SIGNED (Month, Day, Year) 10/19/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 8926 Woodyard Road Clinton, Maryland 20735							
31. DATE FILED (Month, Day, Year) OCT 24 1994				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rendall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 6 and 7 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

smith, charles
Amended #109,166, 10/27/94, CYW, P.G. County

94 33681

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CHARLES R. SMITH				2. DATE OF DEATH MONTH DAY YEAR 10 22 94		3. TIME OF DEATH 2:35PM M					
4. SOCIAL SECURITY NUMBER 215-44-7370		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 86 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 24, 1908		8. BIRTHPLACE (State or Foreign Country) West Virginia			
9a. FACILITY NAME (If not institution, give street and number) Prince Georges Hospital Center				9b. CITY, TOWN OR LOCATION OF DEATH Cheverly			9c. COUNTY OF DEATH Prince Georges				
10a. STATE Maryland				10b. COUNTY Prince Georges		10c. CITY, TOWN OR LOCATION Cheverly		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER 2416 59th Avenue				10f. ZIP CODE 20785		10g. CITIZEN OF WHAT COUNTRY? United States					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Engineer			16b. KIND OF BUSINESS/INDUSTRY Teleph Federal Government						
17. FATHER'S NAME (First, Middle, Last) Charles P. Smith				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sara A. Smith							
19a. INFORMANT'S NAME (Type/Print) Geraldine A. Smith				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2416 59th Avenue, Cheverly, Maryland 20785							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Cemetery 10/26		20c. LOCATION — City or Town, State Brentwood, Maryland							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Neil E. Pine				22. NAME AND ADDRESS OF FACILITY Fort Lincoln Funeral Home, Inc. 3401 Bladensburg Rd., Brentwood, MD 20722							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. - Severe Anemia. DUE TO (OR AS A CONSEQUENCE OF): b. - Metastatic Cancer DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitally flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death one day 10 years			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. - upper Gastrointestinal bleeding - drug deration DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER Sam Tellawi				29c. LICENSE NUMBER D34279		29d. DATE SIGNED (Month, Day, Year) 10-22-94					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Sam Tellawi, M.D., 4000 Mitchellville Road, Bowie, Maryland 20716											
31. DATE FILED (Month, Day, Year) OCT 28 1994				32. REGISTRAR'S SIGNATURE John Davidson-Randall							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33682

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) RUTH LORRAINE STEPHENS				2. DATE OF DEATH MONTH DAY YEAR OCT 16 1994		3. TIME OF DEATH 2:00 P M	
4. SOCIAL SECURITY NUMBER 578-46-0106		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 61 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 19, 1933	
8. FACILITY NAME (If not institution, give street and number) NATIONAL NAVAL MEDICAL CENTER				9. CITY, TOWN OR LOCATION OF DEATH BETHESDA		10. COUNTY OF DEATH MONTGOMERY	
10a. STATE MD		10b. COUNTY PRINCE GEORGE'S		10c. CITY, TOWN OR LOCATION TAKOMA PARK		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 6416 5th AVENUE				10f. ZIP CODE 20912		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 8+) 4 years		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE		16b. KIND OF BUSINESS/INDUSTRY PRIVATE			
17. FATHER'S NAME (First, Middle, Last) WILLIAM H. WOODARD				18. MOTHER'S NAME (First, Middle, Maiden Surname) DAISY WHITE			
19a. INFORMANT'S NAME (Type/Print) EMERSON H. STEPHENS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6416 5th AVE, TAKOMA PK, MD. 20912			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HARMONY MEMORIAL PARK 10/21/94		20c. LOCATION — City or Town, State LANDOVER, MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Belva J. Jenkins				22. NAME AND ADDRESS OF FACILITY JOHNSON & JENKINS INC. 716 KENNEDY ST., N.W. WASH. D.C. 20011			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MYOCARDIAL INFARCTION DUE TO (OR AS A CONSEQUENCE OF): b. END STAGE RENAL DISEASE DUE TO (OR AS A CONSEQUENCE OF): c. DIABETES DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				29. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER G. Denton		29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 17 OCT 94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) G. DENTON, LT, MC, USNR				NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600			
31. DATE FILED (Month, Day, Year) OCT 25 1994		32. REGISTRAR'S SIGNATURE S. Davidson-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, & 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

21 55885

RECEIVED FROM

THE

17

94 33683

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) (Helen Virginia Staley) <i>Helen R. Staley</i>				2. DATE OF DEATH MONTH DAY YEAR 10 21 94		3. TIME OF DEATH 0635 M	
4. SOCIAL SECURITY NUMBER 577-78-3477		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs last birthday) 82 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 8, 1912	
9a. FACILITY NAME (If not institution, give street and number) Washington Adventist Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Takoma Park		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland				10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Brentwood	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 3409 Taylor Street			
10f. ZIP CODE 20722				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Caucasian	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		17. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Lynn Randall				18. MOTHER'S NAME (First, Middle, Maiden Surname) Alley Hines			
19a. INFORMANT'S NAME (Type/Print) James Albert Staley				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3409 Taylor Street, Brentwood, Maryland 20722			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 10/22/94		20c. LOCATION — City or Town, State Alexandria, Virginia			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>W. B. Geiser</i>				22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardiopulmonary Arrest</i> a. DUE TO (OR AS A CONSEQUENCE OF): <i>ischemic Cardiomyopathy</i> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Myelodysplasia with Severe Anemia</i> <i>Dementia ; Azotemia</i>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED					
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> M.D.		29c. LICENSE NUMBER D22549		29d. DATE SIGNED (Month, Day, Year) 10-21-94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) G.M. DIN, M.D. 6510 Kenilworth Ave, Riverdale M.D. 20737							
31. DATE FILED (Month, Day, Year) OCT 25 1994		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33684

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Catherine Ann Stoffel				2. DATE OF DEATH MONTH DAY YEAR October 24, 1994		3. TIME OF DEATH 3:15P M	
4. SOCIAL SECURITY NUMBER 579-01-4004		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 89 YRS.		7. DATE OF BIRTH (Month, Day, Year) 8/16/05	
8. BIRTHPLACE (State or Foreign Country) Washington, D.C.				9a. FACILITY NAME (If not institution, give street and number) Sacred Heart Home		9b. CITY, TOWN OR LOCATION OF DEATH Hyattsville	
9c. COUNTY OF DEATH Prince George's				10a. STATE Maryland		10b. COUNTY Prince George's	
10c. CITY, TOWN OR LOCATION Camp Springs				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 7307 Easy St.	
10f. ZIP CODE 20748				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4 or 5+) 11th				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Clerk		16b. KIND OF BUSINESS/INDUSTRY Credit Bureau	
17. FATHER'S NAME (First, Middle, Last) John J. Cannon				18. MOTHER'S NAME (First, Middle, Maiden Surname) Annie Bridget Kerin			
19a. INFORMANT'S NAME (Type/Print) Tod W. Stoffel				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as item 10			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Cedar Hill Cemetery 10/27/94		20c. LOCATION — City or Town, State Suitland, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George P. Kalas</i>				22. NAME AND ADDRESS OF FACILITY George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md. 20745			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Acute myocardial infarction</i> Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death <i>sudden</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>senile dementia</i>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Peter Schissler</i>				29c. LICENSE NUMBER 022780		29d. DATE SIGNED (Month, Day, Year) 10/25/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Peter Schissler, M.D. 7500 Greenway Center Dr. Greenbelt, Md.							
31. DATE FILED (Month, Day, Year) OCT 25 1994				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician to the FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33685

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LLOYD SCOTT				2. DATE OF DEATH MONTH DAY YEAR OCTOBER 22, 1994		3. TIME OF DEATH 3:43 a.m.	
4. SOCIAL SECURITY NUMBER 579-12-0325		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 16, 1921	
9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH Baltimore	
10a. STATE MD				10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Baltimore city	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 114 Smallwood St			
10f. ZIP CODE 21200				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Truck Driver		16b. KIND OF BUSINESS/INDUSTRY Commerical			
17. FATHER'S NAME (First, Middle, Last) George Scott				18. MOTHER'S NAME (First, Middle, Maiden Surname) Daisy Coleman			
19a. INFORMANT'S NAME (Type/Print) LLOYD SCOTT JR.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1207 White St Fredericksburg Va22401			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Beulah Church Cemetery 10/28/94 Woodford Va.		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Bailey Funeral Home 1207 White St. Fredericksburg Va22401			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF): b. Metastatic Cancer DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death 1 month 1 month
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER DMcKay, MD				29c. LICENSE NUMBER M6340		29d. DATE SIGNED (Month, Day, Year) 10/22/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DMcKay 600 N. Wolfe St. Baltimore, MD 21287							
31. DATE FILED (Month, Day, Year) OCT 27 1994				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33686

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Dorothy Lee Sansbury</i>				2. DATE OF DEATH MONTH DAY YEAR <i>October 22 1994</i>		3. TIME OF DEATH <i>1625</i> M	
4. SOCIAL SECURITY NUMBER <i>237-70-1952</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>51</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>NOV 15, 1942</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>WASHINGTON ADVENTIST HOSPITALS</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>TAKOMA PARK</i>		9c. COUNTY OF DEATH <i>MONTGOMERY</i>	
RESIDENCE OF DECEDENT							
10a. STATE <i>MARYLAND</i>		10b. COUNTY <i>PRINCE GEORGE'S</i>		10c. CITY, TOWN OR LOCATION <i>TAKOMA PARK</i>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>1001 FAIRVIEW AVENUE</i>				10f. ZIP CODE <i>20912</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>BLACK</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>4+</i> College (1-4 or 5+) <i>4+</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>SCHOOL TEACHER</i>		16b. KIND OF BUSINESS/INDUSTRY <i>DIST. of COL. GOVERNMENT</i>			
17. FATHER'S NAME (First, Middle, Last) <i>WILLIE B. JONES</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>EARLENE FELDER</i>			
19a. INFORMANT'S NAME (Type/Print) <i>OSCAR SANSBURY (HUSBAND)</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1001 FAIRVIEW AVENUE, TAKOMA PARK, MARYLAND 20912</i>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>PARKLAWN CEMETERY 10/27/94</i>		20c. LOCATION — City or Town, State <i>ROCKVILLE, MARYLAND</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Juanana L. Blaxton</i>				22. NAME AND ADDRESS OF FACILITY <i>J.B. JENKINS FUNERAL HOME 7474 LANDOVER RD, LANDOVER, MARYLAND 20785</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Metastatic Breast Cancer with metastasis to lung, pleura and liver</i> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Diabetes mellitus</i>							Approximate interval Between Onset and Death <i>1 1/2 years</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetes mellitus</i>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)	
28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Sajeev Anand MD</i>				29c. LICENSE NUMBER <i>D33482</i>		29d. DATE SIGNED (Month, Day, Year) <i>10/23/94</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Sajeev Anand, MD 7227-B Hanover Pky Greenbelt MD 20770</i>							
31. DATE FILED (Month, Day, Year) <i>OCT 27 1994</i>				32. REGISTRAR'S SIGNATURE <i>Juha Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit form filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33687

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JOAN EVELYN SUTPHIN SQUIRES				2. DATE OF DEATH MONTH 10 DAY 20 YEAR 94		3. TIME OF DEATH 1127 M	
4. SOCIAL SECURITY NUMBER 229-50-2015		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 55 YRS.		7. DATE OF BIRTH (Month, Day, Year) 1938 December 15,	
8. BIRTHPLACE (State or Foreign Country) Virginia				9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring	
9c. COUNTY OF DEATH Montgomery				10a. STATE District of Columbia		10b. COUNTY Washington	
10c. CITY, TOWN OR LOCATION Washington				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 3537 - 11th Street, N. W.; Apt. 113	
10f. ZIP CODE 20010				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 years		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Licensed Practical Nurse		16b. KIND OF BUSINESS/INDUSTRY Wisconsin Avenue Nursing Home			
17. FATHER'S NAME (First, Middle, Last) James Pleasant Sutphin				18. MOTHER'S NAME (First, Middle, Maiden Surname) Nanny Oliver Plenty			
19a. INFORMANT'S NAME (Type/Print) James Jerome Squires, Jr. (son)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6-A Westside Village, South Boston, Virginia 24592			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Rose Garden Cemetery		20c. LOCATION — City or Town, State South Boston, Virginia		21. SIGNATURE OF FUNERAL SERVICE LICENSEE Carol Latney Dolan	
22. NAME AND ADDRESS OF FACILITY Latney's Funeral Home 3831 Georgia Avenue, N.W.; Wash. D.C. 20011				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ADULT RESPIRATORY DISEASE SYNDROME DUE TO (OR AS A CONSEQUENCE OF): PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF): NEUTROPENIA DUE TO (OR AS A CONSEQUENCE OF): CHEMOTHERAPY FOR BREAST CANCER Approximate interval between Onset and Death 5 DAY 6 DAY 6 DAY			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER Thomas Tesoriero				29c. LICENSE NUMBER D31124		29d. DATE SIGNED (Month, Day, Year) 10/20/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) THOMAS TESORIERO 1011 NORTH CAPITOL ST NE WASH DC 20002							
31. DATE FILED (Month, Day, Year) OCT 27 1994				32. REGISTRAR'S SIGNATURE John Davidson-Randell			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020



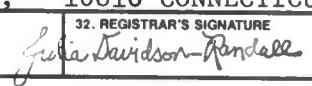
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33688

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) BOBBY E. SUMNER				2. DATE OF DEATH MONTH 10 DAY 20 YEAR 94		3. TIME OF DEATH 12:AM M	
4. SOCIAL SECURITY NUMBER 224-40-6830		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 57 YRS.		7. DATE OF BIRTH (Month, Day, Year) 8/3/37	
8. BIRTHPLACE (State or Foreign Country) Virginis				9a. FACILITY NAME (If not institution, give street and number) 1131 UNIVERSITY BLVD WEST #919		9b. CITY, TOWN OR LOCATION OF DEATH SILVER SPRING	
9c. COUNTY OF DEATH MONTGOMERY				10a. STATE MD		10b. COUNTY MONTGOMERY	
10c. CITY, TOWN OR LOCATION SILVER SPRING				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 1131 UNIVERSITY BLVD WEST #919	
10f. ZIP CODE 20902				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Yrs College (1-4 or 5+) None				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Barber		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) James Sumner				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lula Bullock			
19a. INFORMANT'S NAME (Type/Print) Carmen Sumner				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as 10a,b,c,d,e,&f			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Gate of Heaven		20c. LOCATION — City or Town, State 10/25/94 Silver Spring, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY John T. Rhines Co., Inc. 3030 12th St NE, DC 20017			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → s. Hypercalcemia DUE TO (OR AS A CONSEQUENCE OF): b. Squamous Cell carcinoma, Basaloid Variant, Origin from Oropharynx (Retrolar Trigone) DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death Months 1 Yr							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D34590		29d. DATE SIGNED (Month, Day, Year) 10/21/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ROY FRIED, MD, 10810 CONNECTICUT AVENUE/KENSINGTON, MD.							
31. DATE FILED (Month, Day, Year) OCT 24 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

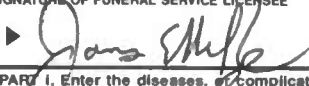

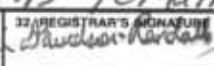
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33689

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARIE SELMA SHAW				2. DATE OF DEATH MONTH DAY YEAR OCTOBER 27, 1994		3. TIME OF DEATH 9:35 a.m.	
4. SOCIAL SECURITY NUMBER 219-80-5162		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 80 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 23, 1914	
8a. FACILITY NAME (If not institution, give street and number) SACRED HEART HOSPITAL				8b. CITY, TOWN OR LOCATION OF DEATH Cumberland		8c. COUNTY OF DEATH ALLEGANY	
RESIDENCE OF DECEDENT							
10a. STATE Md		10b. COUNTY Allegany		10c. CITY, TOWN OR LOCATION Barton		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 18402 Moscow St. S.W.				10f. ZIP CODE 21521		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify		14. RACE — American Indian, Black, White, etc. White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Home			
17. FATHER'S NAME (First, Middle, Last) Patrick O'Halloran				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Miller			
19a. INFORMANT'S NAME (Type/Print) Norma Nelson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 West Main St., Lonaconing, Md. 21539			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Laurel Hill Cemetery 10-31-94		20c. LOCATION — City or Town, State Moscow Mills, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Eichhorn-McKenzie Funeral Home Lonaconing, Md. 21539			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiac Arrest Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Coronary Artery Disease, decompensate 8 months Respiratory Failure w/ Respirator 8 months Peripartum Vascular Disease 2 yrs							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. poliomyelitis bilateral leg							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D15463		29d. DATE SIGNED (Month, Day, Year) 10/28/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) Kim Shin M.D. 90 Main Street Westernport, MD 21562							
31. DATE FILED (Month, Day, Year) NOV 03 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33690

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) WILLIAM MICHAEL SHIPLEY				2. DATE OF DEATH MONTH DAY YEAR NOVEMBER 1 1994		3. TIME OF DEATH 0703 A.M. M	
4. SOCIAL SECURITY NUMBER 219-54-2136		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 44 YRS.		7. DATE OF BIRTH (Month, Day, Year) OCT 24 1950	
9a. FACILITY NAME (If not institution, give street and number) MEMORIAL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND		9c. COUNTY OF DEATH ALLEGANY	
10a. STATE MARYLAND				10b. COUNTY ALLEGANY		10c. CITY, TOWN OR LOCATION CUMBERLAND	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 222 PACA STREET			
10f. ZIP CODE 21502				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) OWNER/OPERATOR SHIPLEY ENTERPRIZE		16b. KIND OF BUSINESS/INDUSTRY STONE MASON			
17. FATHER'S NAME (First, Middle, Last) WILLIAM O. SHIPLEY				18. MOTHER'S NAME (First, Middle, Maiden Surname) JEAN GRAPES			
19a. INFORMANT'S NAME (Type/Print) SUZANNE SHIPLEY				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 222 PACA STREET CUMBERLAND MARYLAND 21502			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) SALEM CEMETERY NOV 4 1994		20c. LOCATION — City or Town, State Slanesville W.VA.		20d. DATE NOV 4 1994	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dale L. Merritt</i>				22. NAME AND ADDRESS OF FACILITY MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Septicemia 2° Klebsiella DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Severe Rheumatoid disease Dilated Cardiomyopathy							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA		26. PLACE OF DEATH (Check only one) OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>R. Barrera</i>				29c. LICENSE NUMBER D 14865		29d. DATE SIGNED (Month, Day, Year) NOVEMBER 1, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ROBUSTIANO BARRERA M.D. MEMORIAL HOSPITAL MEDICAL BLDG CUMBERLAND MARYLAND							
31. DATE FILED (Month, Day, Year) NOV 02 1994				32. REGISTRAR'S SIGNATURE <i>H. Tucker-Rodell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33691

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ELLIS EUGENE SEE				2. DATE OF DEATH MONTH 10 DAY 25 YEAR 94		3. TIME OF DEATH 05:20am^M	
4. SOCIAL SECURITY NUMBER 721 16 9543		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		7. DATE OF BIRTH (Month, Day, Year) 01 27 21	
8. BIRTHPLACE (State or Foreign Country) West Virginia				9a. FACILITY NAME (If not institution, give street and number) Sacred Heart Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Cumberland	
9c. COUNTY OF DEATH Allegany				10a. STATE WV		10b. COUNTY Hampshire	
10c. CITY, TOWN OR LOCATION Purgitsville				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER HC 66 Box 8	
10f. ZIP CODE 26852				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (14 or 5+) DOZER OPERATOR				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DOZER OPERATOR		16b. KIND OF BUSINESS/INDUSTRY Construction	
17. FATHER'S NAME (First, Middle, Last) Homer Roy See				18. MOTHER'S NAME (First, Middle, Maiden Surname) Emily Vance Martin			
19a. INFORMANT'S NAME (Type/Print) Alma F. See				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) HC 66, Box 8, Purgitsville, WV 26852			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) Indian Mound Cemetery 10/27/94		20c. LOCATION — City or Town, State Romney, WV	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Mark Huffer</i>				22. NAME AND ADDRESS OF FACILITY Shaffer Funeral Home, Inc. 230 East Main St., Romney, WV 26757			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Severe respiratory failure DUE TO (OR AS A CONSEQUENCE OF): COPD Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST c. G.I. Bleeding DUE TO (OR AS A CONSEQUENCE OF): Post-operative anastomosis d. Post-operative anastomosis							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>John N. Mehanna</i>	
29c. LICENSE NUMBER D-17526				29d. DATE SIGNED (Month, Day, Year) 10-25-94		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print) John N. Mehanna M.D. 902 Seton Drive, Cumberland, MD 21502	
31. DATE FILED (Month, Day, Year) OCT 27 1994				32. REGISTRAR'S SIGNATURE <i>Davidson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1000 12

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94 33692

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) SIDNEY S. STEVENSON				2. DATE OF DEATH MONTH 11 - DAY 07 - YEAR 94		3. TIME OF DEATH 1630	
4. SOCIAL SECURITY NUMBER 214-01-7947		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 82 YRS.		7. DATE OF BIRTH (Month, Day, Year) 02-29-1912	
9a. FACILITY NAME (If not institution, give street and number) WATERVIEW HEALTH CARE CENTER				9b. CITY, TOWN OR LOCATION OF DEATH Salisbury, MD.		9c. COUNTY OF DEATH Wicomico	
10a. STATE MD				10b. COUNTY SOMERSET		10c. CITY, TOWN OR LOCATION Princess Anne	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 30122 DEALS ISLAND RD			
10f. ZIP CODE 21853				10g. CITIZEN OF WHAT COUNTRY? U.S.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4 or 5+) 		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LABORER		16b. KIND OF BUSINESS/INDUSTRY MECHANIC			
17. FATHER'S NAME (First, Middle, Last) Sip STEVENSON				18. MOTHER'S NAME (First, Middle, Maiden Surname) Addie COTMAN			
19a. INFORMANT'S NAME (Type/Print) HAZEL Milbourne				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30122 DEALS ISLAND RD. Princess Anne, MD. 21853			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) John Wesley Cem. 11/5/94		20c. LOCATION — City or Town, State Princess Anne, MD.		20d. DATE 11/5/94	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Anthony E. Ward</i>				22. NAME AND ADDRESS OF FACILITY ANTHONY E. WARD Funeral Home 30639 HAMPTON AVE. Princess Anne, MD 21853			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Leukemia, probably myelocytic DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death 7 weeks
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia, Thrombocytopenia, Renal Insufficiency							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Thomas C. Hill Jr. Medical Director</i>				29c. LICENSE NUMBER D08008		29d. DATE SIGNED (Month, Day, Year) 11-01-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) THOMAS C. Hill Jr. 108 Pine Bluff Rd, Salisbury, Md 21801							
31. DATE FILED (Month, Day, Year) NOV 04 1994				32. REGISTRAR'S SIGNATURE <i>John Anderson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

202

MD 01-01-11 * 82

Winter View Health Care Center Salisbury, MD

MD Somerset

3018 Derry Island Rd

Black

101-101

2.9 Stevenson

Hotel Wilkesboro

2012 Derry Island Rd Salisbury, MD

2012 Derry Island Rd Salisbury, MD

NOV 1 1984

94 33693

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) THELMA STANLEY				2. DATE OF DEATH MONTH DAY YEAR 10-30-1994		3. TIME OF DEATH M M	
4. SOCIAL SECURITY NUMBER 429-03-3694		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 76 YRS.		7. DATE OF BIRTH (Month, Day, Year) 6-7-1918	
9a. FACILITY NAME (If not institution, give street and number) ANNE ARUNDEL MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH ANNAPOLIS		9c. COUNTY OF DEATH ANNE ARUNDEL	
10a. STATE MARYLAND				10b. COUNTY ANNE ARUNDEL		10c. CITY, TOWN OR LOCATION SEVERNA PARK	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 467 BLACKSHIRE ROAD			
10f. ZIP CODE 21146				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: CAUCASIAN	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12+ College (1-4 or 8+) MANAGER		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY DRYCLEANING			
17. FATHER'S NAME (First, Middle, Last) CHARLES HUDSON				18. MOTHER'S NAME (First, Middle, Maiden Surname) RUBY CHEATHAM			
19a. INFORMANT'S NAME (Type/Print) MRS. MARNETTE PRICE				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 467 BLACKSHIRE RD. SEVERNA PARK, MD 21146			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) METRO CREMATORY 11-1-94		20c. LOCATION — City or Town, State BALTIMORE, MD		20d. DATE 11-1-94	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James E. Parsons</i>				22. NAME AND ADDRESS OF FACILITY BARRANCO & SONS F.H. 495 RITCHIE HWY SEVERNA PARK, MD 21146			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>southly myeloma</i> Approximate Interval Between Onset and Death a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Stanley P. Watkins</i>				29c. LICENSE NUMBER D58118		29d. DATE SIGNED (Month, Day, Year) NOV 02 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Stanley P. Watkins, 900 Bestgate Rd Annapolis Md. 21401							
31. DATE FILED (Month, Day, Year) NOV 02 1994				32. REGISTRAR'S SIGNATURE <i>Julia S. Russell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

UNITED STATES DEPARTMENT OF AGRICULTURE

Report of the
Commissioner of the
General Land Office
for the year ending
June 30, 1900

Presented to the
Senate and House of Representatives
at their special session, called for the purpose
of considering the report of the
Commissioner of the General Land Office,
for the year ending June 30, 1900.

WASHINGTON:
GOVERNMENT PRINTING OFFICE:
1901.

5

94 33694

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) KETTY L. SMITH				2. DATE OF DEATH MONTH DAY YEAR OCT. 27 1994		3. TIME OF DEATH M M	
4. SOCIAL SECURITY NUMBER 219-78-3000		5. SEX 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. MONTHS DAYS 23		7. DATE OF BIRTH (Month, Day, Year) 7 23 1962	
9a. FACILITY NAME (If not institution, give street and number) 424 CHESAPEAKE AVENUE				9b. CITY, TOWN OR LOCATION OF DEATH ANNAPOLIS		9c. COUNTY OF DEATH ANNE ARUNDEL	
RESIDENCE OF DECEASED							
10a. STATE MARYLAND		10b. COUNTY ANNE ARUNDEL		10c. CITY, TOWN OR LOCATION ANNAPOLIS		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 424 CHESAPEAKE AVENUE				10f. ZIP CODE 21403		10g. CITIZEN OF WHAT COUNTRY? U.S.	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 1 yr.		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. DO NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY AIR CARGO			
17. FATHER'S NAME (First, Middle, Last) RUDOLPH SMITH				18. MOTHER'S NAME (First, Middle, Maiden Surname) JEANNETTE DUCKETT			
19a. INFORMANT'S NAME (Type/Print) JEANNETTE SMITH				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 424 CHESAPEAKE AVE. ANNAPOLIS, MD. 21403			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ANNAPOLIS MEM. GARDENS 10/31/94		20c. LOCATION — City or Town, State ANNAPOLIS, MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Harry J. Reese				22. NAME AND ADDRESS OF FACILITY REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Disseminated MAI							
b. AIDS							
c. Due to (or as a consequence of):							
d. Due to (or as a consequence of):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Charles W. Phelps MD				29c. LICENSE NUMBER D41816		29d. DATE SIGNED (Month, Day, Year) 10/31/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Charles W. Phelps 180 Admiral Cochrane Dr. Annapolis, Md. 21401							
31. DATE FILED (Month, Day, Year) NOV 03 1994				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the death certificate. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33695

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) SARAH ELENOR TRESSLER				2. DATE OF DEATH MONTH 10 DAY 26 YEAR 94		3. TIME OF DEATH 2240	
4. SOCIAL SECURITY NUMBER 242-24-4915		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 69 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 13, 1925	
8. BIRTHPLACE (State or Foreign Country) North Carolina				9a. FACILITY NAME (If not institution, give street and number) 13234 Glissans Mill Rd.		9b. CITY, TOWN OR LOCATION OF DEATH Mt. Airy	
9c. COUNTY OF DEATH Frederick				10a. STATE Maryland		10b. COUNTY Frederick	
10c. CITY, TOWN OR LOCATION Mt. Airy				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 13234 Glissans Mill Rd.	
10f. ZIP CODE 21771				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) homemaker		16b. KIND OF BUSINESS/INDUSTRY own home	
17. FATHER'S NAME (First, Middle, Last) Walter Hale				18. MOTHER'S NAME (First, Middle, Maiden Surname) Phoebe (unknown)			
19a. INFORMANT'S NAME (Type/Print) Flossie B. Layton				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10606 Bethel Rd. Frederick, MD 21702			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Locust Grove Cemetery		20c. LOCATION — City or Town, State 10/29 nr. Mt. Airy, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Catherine O. Hartzler</i>				22. NAME AND ADDRESS OF FACILITY D.D. Hartzler & Sons Libertytown, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): b. DIABETES MELLITUS DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____ _____							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M 1 YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Robert R. Roberts MD</i>				29c. LICENSE NUMBER D09867		29d. DATE SIGNED (Month, Day, Year) 10/26/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RRR ROBERTS MD 15 W 7TH STREET FREDERICK MD 21701-4599							
31. DATE FILED (Month, Day, Year) NOV 02 1994				32. REGISTRAR'S SIGNATURE <i>David R. Hall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33696

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Douglas Delbert Taylor				2. DATE OF DEATH MONTH DAY YEAR October 27, 1994		3. TIME OF DEATH 5:30 A. M.	
4. SOCIAL SECURITY NUMBER 579-05-4269		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan. 16, 1909	
9a. FACILITY NAME (If not institution, give street and number) Wilson Health Care Center				9b. CITY, TOWN OR LOCATION OF DEATH Gaithersburg		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Gaithersburg		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 407 Russell Avenue				10f. ZIP CODE 20877		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Carpenter		16b. KIND OF BUSINESS/INDUSTRY Home Construction			
17. FATHER'S NAME (First, Middle, Last) Oscar Hughes Taylor				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Elizabeth Barr			
19a. INFORMANT'S NAME (Type/Print) Mae G. Taylor				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 407 Russell Avenue, #203, Gaithersburg, MD. 20877			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory		DATE 10/27		20c. LOCATION — City or Town, State Alexandria, Virginia	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael D. Culbary</i>				22. NAME AND ADDRESS OF FACILITY DeVol Funeral Home 10 E. Deer Park Dr., Gaithersburg, MD. 20877			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Aspiration Pneumonia DUE TO (OR AS A CONSEQUENCE OF): b. Stroke DUE TO (OR AS A CONSEQUENCE OF): c. Hypertension DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Depression							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Byrl D. Johnson M.D.</i>				29c. LICENSE NUMBER D 19042		29d. DATE SIGNED (Month, Day, Year) October 27, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Byrl D. Johnson, M.D., 911 Russell Avenue, Gaithersburg, Maryland 20879-3266							
31. DATE FILED (Month, Day, Year) OCT 28 1994				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33697

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Sushila Devi Talwar				2. DATE OF DEATH MONTH DAY YEAR October 22, 1994				3. TIME OF DEATH 5:00 P M		
4. SOCIAL SECURITY NUMBER 212-43-7461		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 70 YRS.		7. DATE OF BIRTH (Month, Day, Year) October 1, 1924		8. BIRTHPLACE (State or Foreign Country) India		
9a. FACILITY NAME (If not institution, give street and number) 14345 Stilton Circle				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring				9c. COUNTY OF DEATH Montgomery		
10a. STATE Maryland			10b. COUNTY Montgomery			10c. CITY, TOWN OR LOCATION Silver Spring			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 14345 Stilton Circle				10f. ZIP CODE 20904		10g. CITIZEN OF WHAT COUNTRY? India				
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Hindu			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (14 or 5+) 8				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife			16b. KIND OF BUSINESS/INDUSTRY Homemaker			
17. FATHER'S NAME (First, Middle, Last) Ram Lubhya Tandon				18. MOTHER'S NAME (First, Middle, Maiden Surname) Chandan Devi Sehgal						
19a. INFORMANT'S NAME (Type/Print) Deepak Ohri				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14345 Stilton Circle Silver Spring, Maryland 20904						
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 10/23/94		20c. LOCATION — City or Town, State Alexandria, Virginia						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ► <i>Steven D. Stroud</i>				22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Acute Respiratory failure</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Metastatic Mucin producing Adenocarcinoma</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>Pancreatic Malignancy</i> DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST									Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypertension, Coronary Artery disease</i>									24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined			28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER <i>D. R. Rustagi MD</i>				29c. LICENSE NUMBER D24720			29d. DATE SIGNED (Month, Day, Year) ► 10-22-94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) D. R. RUSTAGI 6132 LANDOVER ROAD, CHEVERLY, MD 20785										
31. DATE FILED (Month, Day, Year) OCT 24 1994				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>						

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33698

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) William Luther Trott Jr.				2. DATE OF DEATH MONTH DAY YEAR Oct. 24, 1994		3. TIME OF DEATH 7:50A M	
4. SOCIAL SECURITY NUMBER 212-12-9798		5. SEX 1 M 2 F		6. AGE (In yrs. last birthday) 75 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct. 7, 1919	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) 12800 9th. St.		9b. CITY, TOWN OR LOCATION OF DEATH Bowie	
9c. COUNTY OF DEATH P.G.				10a. STATE MD.		10b. COUNTY P.G.	
10c. CITY, TOWN OR LOCATION Bowie				10d. INSIDE CITY LIMITS? 1 YES 2 NO		10e. STREET AND NUMBER 12800 9th. St.	
10f. ZIP CODE 20720				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 NEVER MARRIED 2 MARRIED 3 WIDOWED 4 DIVORCED		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Printer		16b. KIND OF BUSINESS/INDUSTRY Newspaper			
17. FATHER'S NAME (First, Middle, Last) William L. Trott Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Clara Virginia Bell			
19a. INFORMANT'S NAME (Type/Print) Dorothy Elizabeth Trott				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12800 9th. St., Bowie, MD. 20720			
20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Chambers Crematory 10/25		20c. LOCATION — City or Town, State Riverdale, MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Thomas S. Chambers</i> #670				22. NAME AND ADDRESS OF FACILITY W.W. Chambers Co. Inc. 5801 Cleveland Ave. Riverdale, MD. 20737			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Lung Cancer - metastatic DUE TO (OR AS A CONSEQUENCE OF): b. atrial fibrillation DUE TO (OR AS A CONSEQUENCE OF): c. chronic obstructive pulmonary disease DUE TO (OR AS A CONSEQUENCE OF): d. hypertension							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. atrial fibrillation; hypertension							24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO							DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)					
27. MANNER OF DEATH 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 YES 2 NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Rachelle M. Alexion</i>				29c. LICENSE NUMBER D44156 Maryland		29d. DATE SIGNED (Month, Day, Year) 10/24/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RACHELLE ALEXION 14300 Gallant Fox Lane #118 Bowie, MD 20715							
31. DATE FILED (Month, Day, Year) OCT 25 1994				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Q. 1. The first part of the document is a list of names and addresses. The names are: John Doe, Jane Doe, and John Doe. The addresses are: 123 Main St, 456 Main St, and 789 Main St. The names and addresses are listed in the following order: John Doe, 123 Main St; Jane Doe, 456 Main St; John Doe, 789 Main St.

Q. 2. The second part of the document is a list of names and addresses. The names are: John Doe, Jane Doe, and John Doe. The addresses are: 123 Main St, 456 Main St, and 789 Main St. The names and addresses are listed in the following order: John Doe, 123 Main St; Jane Doe, 456 Main St; John Doe, 789 Main St.

Q. 3. The third part of the document is a list of names and addresses. The names are: John Doe, Jane Doe, and John Doe. The addresses are: 123 Main St, 456 Main St, and 789 Main St. The names and addresses are listed in the following order: John Doe, 123 Main St; Jane Doe, 456 Main St; John Doe, 789 Main St.

Q. 4. The fourth part of the document is a list of names and addresses. The names are: John Doe, Jane Doe, and John Doe. The addresses are: 123 Main St, 456 Main St, and 789 Main St. The names and addresses are listed in the following order: John Doe, 123 Main St; Jane Doe, 456 Main St; John Doe, 789 Main St.

Q. 5. The fifth part of the document is a list of names and addresses. The names are: John Doe, Jane Doe, and John Doe. The addresses are: 123 Main St, 456 Main St, and 789 Main St. The names and addresses are listed in the following order: John Doe, 123 Main St; Jane Doe, 456 Main St; John Doe, 789 Main St.

94 33699

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) John Anthony Todd				2. DATE OF DEATH MONTH 10 DAY 30 YEAR 1994		3. TIME OF DEATH 0715 M	
4. SOCIAL SECURITY NUMBER 150 - 09 - 6731		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 84 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 3, 1910	
8. BIRTHPLACE (State or Foreign Country) Pennsylvania				9. CITY, TOWN OR LOCATION OF DEATH Elkton		10. COUNTY OF DEATH Cecil	
11. FACILITY NAME (If not institution, give street and number) Union Hospital of Cecil County				12. CITY, TOWN OR LOCATION Margate		13. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
14. STATE New Jersey		15. COUNTY Atlantic		16. CITY, TOWN OR LOCATION Margate		17. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
18. STREET AND NUMBER 8301 Ventnor Avenue				19. ZIP CODE 08402		20. CITIZEN OF WHAT COUNTRY? United States	
21. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		22. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		23. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		24. RACE — American Indian, Black, White, etc. Specify: White	
25. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		26. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Florist		27. KIND OF BUSINESS/INDUSTRY Retail Floral Sales			
28. FATHER'S NAME (First, Middle, Last) Joseph M. Todd				29. MOTHER'S NAME (First, Middle, Maiden Surname) Irene Miller			
30. INFORMANT'S NAME (Type/Print) J. Anthony Todd				31. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 400 N. Quincy Avenue, Margate, N.J. 08402			
32. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		33. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Holy Cross Cemetery		34. DATE 11/4/94		35. LOCATION — City or Town, State Mays Landing, New Jersey	
36. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert G. Crouch</i>				37. NAME AND ADDRESS OF FACILITY Crouch Funeral Home 127 South Main Street, North East MD 21901			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ASCVD DUE TO (OR AS A CONSEQUENCE OF): b. TOBACCO USAGE DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28. DATE OF INJURY (Month, Day, Year) 29. TIME OF INJURY 30. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		31. DESCRIBE HOW INJURY OCCURRED 32. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 33. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
34. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
35. SIGNATURE AND TITLE OF CERTIFIER <i>David Ratcliff M.D.</i>				36. LICENSE NUMBER D55040		37. DATE SIGNED (Month, Day, Year) NOV 30, 94	
38. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DAVID RATCLIFF M.D. 106 Bow St ELKTON, Md 21921							
39. DATE FILED (Month, Day, Year) NOV 01 '94		40. REGISTRAR'S SIGNATURE <i>John Davidson-Rodwell</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit certificate and filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-1A Rev 1/89

94 33701

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CLINTON TONGUE SR.				2. DATE OF DEATH MONTH DAY YEAR OCT 28 1994		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 212-16-2439		5. SEX XXX M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) JULY 4 -16	
8a. FACILITY NAME (If not institution, give street and number) NN AUTO-LANSDALE RD. A.A.CO				8b. CITY, TOWN OR LOCATION OF DEATH RURAL LANSDALE RD.		8c. COUNTY OF DEATH ANNE ARUNDEL	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY ANNE ARUNDEL		10c. CITY, TOWN OR LOCATION HARWOOD		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 4309 MUDDY CREEK RD.				10f. ZIP CODE 20776		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: AFRO AMERICAN	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) ??				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CONSTRUCTION LABORER		16b. KIND OF BUSINESS/INDUSTRY ###	
17. FATHER'S NAME (First, Middle, Last) ELI TONGUE				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARTHA JOHNSON			
19a. INFORMANT'S NAME (Type/Print) FLORENCE TONGUE				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS 10 E			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) CHEWS U. METH CH. 11-3-94		20c. LOCATION (City or Town, State) HARWOOD A.A.CO.MD		20d. DATE OF DISPOSITION 11-3-94	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE CHARLES E. HICKS 111				22. NAME AND ADDRESS OF FACILITY ANNAPOLIS MD. 21401 HOUSE OF HICKS 1922 FOREST DRIVE			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute coronary Occlusion DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death: minutes Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) In his car on Lansdale Road					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED No injury				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Charles H. Wirth				29c. LICENSE NUMBER D 12572		29d. DATE SIGNED (Month, Day, Year) 10/31/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. Charles H. Wirth - 4837 Solomons Island Rd. Lothian, MD. 20776							
31. DATE FILED (Month, Day, Year) NOV 01 1994				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020
 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33702

ITEMS: 27, 28a-f, PER MEO FILM G-721 3/2/95 t.t.

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) EVA MYRA UMSTOT				2. DATE OF DEATH MONTH DAY YEAR October 25, 1994		3. TIME OF DEATH 3:18 P M	
4. SOCIAL SECURITY NUMBER 214-07-4313		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 89 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug 9, 1905	
9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Cumberland		9c. COUNTY OF DEATH Allegany	
10a. STATE WV				10b. COUNTY Mineral		10c. CITY, TOWN OR LOCATION Short Gap	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER R.D. 2 Box 128			
10f. ZIP CODE 27667				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Retired		16b. KIND OF BUSINESS/INDUSTRY Textile	
17. FATHER'S NAME (First, Middle, Last) U. Gilmore Umstot				18. MOTHER'S NAME (First, Middle, Maiden Surname) Delara (Skelley)			
19a. INFORMANT'S NAME (Type/Print) Sharon Pyles				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Route 2 Box 126-D; Keyser, WV 26726			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Ashby Cemetery		20c. LOCATION — City or Town, State 10/28 Fort Ashby, WV		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE James S. Scarpelli				22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Massive Intra Cerebella H/ge b. Cerebr Vasculr Accident c. Cerebr Atherosclerosis d. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Old age							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) OCT. 25, 1994		28b. TIME OF INJURY 12:41 P M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED FELL DOWN STEPS		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) HOME		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) SAME AS #10			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER N.A. Ranjithan				29c. LICENSE NUMBER D 19318		29d. DATE SIGNED (Month, Day, Year) 10/26/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Ranjithan, 517 Oldtown Road, Cumberland, MD 21502							
31. DATE FILED (Month, Day, Year) OCT 26 1994				32. REGISTRAR'S SIGNATURE Brendan R. R. R.			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0060
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JOHN CHARLES VALENTINE				2. DATE OF DEATH MONTH 10 DAY 26 YEAR 94		3. TIME OF DEATH 23:10 PM	
4. SOCIAL SECURITY NUMBER 220-38-0427		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 54 YRS.		7. DATE OF BIRTH (Month, Day, Year) AUGUST 10 1940 MARYLAND	
9a. FACILITY NAME (If not institution, give street and number) MEMORIAL HOSP. & MEDICAL CTR.				9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND, MD		9c. COUNTY OF DEATH ALLEGANY	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY ALLEGANY		10c. CITY, TOWN OR LOCATION LAVALE		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 23 VOCKE DRIVE				10f. ZIP CODE 21502		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (13-16 or 17+)		18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Owner/Operator of Valentine Auto Repair		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) (UNK)				18. MOTHER'S NAME (First, Middle, Maiden Surname) CARRIE MAE VALENTINE			
19a. INFORMANT'S NAME (Type/Print) ROSALIE VALENTINE				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23 VOCKE DRIVE LALALE, MARYLAND 21502			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GREENMOUNT CEMETERY OCT 29 1994		DATE Cumberland Maryland		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dale L. Merritt</i>				22. NAME AND ADDRESS OF FACILITY MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic renal cell CA DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							24c. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>H.C. Merrick</i>				29c. LICENSE NUMBER D 28910		29d. DATE SIGNED (Month, Day, Year) 10/27/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. H.C. MERRICK, MEMORIAL HOSPITAL MEDICAL BLDG., CUMBERLAND, MD							
31. DATE FILED (Month, Day, Year) OCT 28 1994				32. REGISTRAR'S SIGNATURE <i>Julia Swanson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020
 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33704

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) GLADYS Hawley WOODCOCK				2. DATE OF DEATH MONTH 10 DAY 20 YEAR 94		3. TIME OF DEATH 7:10 P M	
4. SOCIAL SECURITY NUMBER 079-32-7534		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 87 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 23, 1907	
9a. FACILITY NAME (If not institution, give street and number) Montgomery General Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Olney		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland				10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 1620 Hutchinson Lane				10f. ZIP CODE 20906		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) 3		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Registered Nurse		16b. KIND OF BUSINESS/INDUSTRY Health Care			
17. FATHER'S NAME (First, Middle, Last) Peter Hawley				18. MOTHER'S NAME (First, Middle, Maiden Surname) Jenny Marsh			
19a. INFORMANT'S NAME (Type/Print) Synthia Woodcock-Dang				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as 10			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Suburban Crematory		DATE 10-21		20c. LOCATION — City or Town, State Silver Spring, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ellen H. Rapp				22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF): Coronary For infarction Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST T1 Myeloma 2° to osteoporosis & fracture						Approximate Interval Between Onset and Death 7 days 7 days	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA		26. PLACE OF DEATH (Check only one) OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Evelyn Jackson				29c. LICENSE NUMBER 025947		29d. DATE SIGNED (Month, Day, Year) 10/20/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Evelyn Jackson, M. D., 5540 Ten Oaks Road, Clarksville, MD 21029							
31. DATE FILED (Month, Day, Year) OCT 24 1994				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33705

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) John F. Whittemore				2. DATE OF DEATH MONTH DAY YEAR October 23, 1994		3. TIME OF DEATH 11:46A ^M	
4. SOCIAL SECURITY NUMBER 126-09-6550		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 26, 1921	
8. BIRTHPLACE (State or Foreign Country) Nebraska				9a. FACILITY NAME (If not institution, give street and number) Shady Grove Adventist Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Rockville	
9c. COUNTY OF DEATH Montgomery				10a. STATE Florida		10b. COUNTY Palm Beach	
10c. CITY, TOWN OR LOCATION W. Palm Beach				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 13388 Polo Road West B-301	
10f. ZIP CODE 33414				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES World War II				13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Civil Engineer		16b. KIND OF BUSINESS/INDUSTRY Manufacturing	
17. FATHER'S NAME (First, Middle, Last) John F. Whittemore				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ida Alexander			
19a. INFORMANT'S NAME (Type/Print) Alma H. Whittemore				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1602 S. Main Street, N. Canton, Ohio 44709			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc. 10/26/94		20c. LOCATION — City or Town, State Bethesda, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Nicholas P. Kutta M00348				22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Rockville, Inc., 300 W. Montgomery Ave. Rockville, Maryland 20850-2805			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory Arrest then Cardiac Collapse Minutes DUE TO (OR AS A CONSEQUENCE OF): b. Respiratory Infection Days DUE TO (OR AS A CONSEQUENCE OF): c. Cerebral Vascular Accident Months DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebral Vascular Accident with Respiratory Infection DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Gary W. Langston, MD				29c. LICENSE NUMBER D17947		29d. DATE SIGNED (Month, Day, Year) October 25, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GARY W. LANGSTON MD, 9901 Medical Center Dr, Rockville, MD 20850							
31. DATE FILED (Month, Day, Year) OCT 27 1994				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Amended # 18, 10/28/94, J.W., Montgomery G094 33706

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Keith Martin West				2. DATE OF DEATH MONTH DAY YEAR October 23, 1994				3. TIME OF DEATH 7:30 A M	
4. SOCIAL SECURITY NUMBER 104-44-3807		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 40 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct. 31, 1953		8. BIRTHPLACE (State or Foreign Country) New York	
9a. FACILITY NAME (If not institution, give street and number) 9737 Mt. Pisgah Road, #708				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring				9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland				10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring			
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 9737 Mt. Pisgah Road, #708				10f. ZIP CODE 20903	
10g. CITIZEN OF WHAT COUNTRY? United States				11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE - American Indian, Black, White, etc. Specify: Black				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Librarian 16b. KIND OF BUSINESS/INDUSTRY Library	
17. FATHER'S NAME (First, Middle, Last) George M. West, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Edith C. Jackson Jackson				19a. INFORMANT'S NAME (Type/Print) Diana E. Thompson	
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18 Lee Ann Drive, Blackwood, NJ 08012				20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Suburban Crematory 20c. LOCATION - City or Town, State 10-24 Silver Spring, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ellen H. Rapp				22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. AIDS DUE TO (OR AS A CONSEQUENCE OF): b. HIV Infection DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide	
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY - At home, term, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER Gary L. Simon				29c. LICENSE NUMBER 12162	
29d. DATE SIGNED (Month, Day, Year) October 24, 1994				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Gary L. Simon, M. D., 2150 Pennsylvania Avenue, NW, Washington, DC 20037				31. DATE FILED (Month, Day, Year) OCT 28 1994	
32. REGISTRAR'S SIGNATURE Julia Davidson-Rendell									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

Amended # 20c, 10/28/94, J.V., Montgomery Co. 94 33707

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Gustave Adolph Wohlfort						2. DATE OF DEATH MONTH DAY YEAR Oct. 24, 1994		3. TIME OF DEATH 12:15 A. M.	
4. SOCIAL SECURITY NUMBER 057-07-4381		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 91 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 13, 1903		8. BIRTHPLACE (State or Foreign Country) New York	
9a. FACILITY NAME (If not institution, give street and number) Wilson Health Care Center						9b. CITY, TOWN OR LOCATION OF DEATH Gaithersburg		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT									
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Gaithersburg				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 401 Russell Ave. #403						10f. ZIP CODE 20877		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Certified Public Accountant			16b. KIND OF BUSINESS/INDUSTRY Fritzche Brothers		
17. FATHER'S NAME (First, Middle, Last) Gustave Wohlfort						18. MOTHER'S NAME (First, Middle, Maiden Surname) Edith Haekle			
19a. INFORMANT'S NAME (Type/Print) Robert W. Wohlfort						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17817 Caddy Dr., Derwood, Maryland 20855			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory			DATE 10/26		20c. LOCATION — City or Town, State Alexandria, Virginia		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 						22. NAME AND ADDRESS OF FACILITY De Vol Funeral Home 10 E. Deer Park Dr., Gaithersburg, MD 20877			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multi-infarct dementia DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER 						29c. LICENSE NUMBER D18186		29d. DATE SIGNED (Month, Day, Year) 10/28/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Steven Levenson, M.D. 301 Russell Ave., Gaithersburg, Maryland 20877									
31. DATE FILED (Month, Day, Year) OCT 28 1994						32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33708

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) James Augustine Wells				2. DATE OF DEATH MONTH 10 DAY 18 YEAR 1994		3. TIME OF DEATH 7:10 A M	
4. SOCIAL SECURITY NUMBER 579-40-9714		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 67 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 13, 1927	
8. BIRTHPLACE (State or Foreign Country) Massachusetts				9a. FACILITY NAME (If not institution, give street and number) Villa Rosa Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH Mitchellville	
9c. COUNTY OF DEATH Prince George's				10a. STATE Maryland		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION Rockville				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 834 New Mark Esplanade	
10f. ZIP CODE 20850				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES World War II				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: White				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) District Manager				16b. KIND OF BUSINESS/INDUSTRY Air Freight			
17. FATHER'S NAME (First, Middle, Last) Lester Allen Wells				18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth Shriver			
19a. INFORMANT'S NAME (Type/Print) Margaretha Wells				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 834 New Mark Esplanade, Rockville, Maryland 20850			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc. 10/20/94			
20c. LOCATION — City or Town, State Bethesda, Maryland				21. SIGNATURE OF FUNERAL SERVICE LICENSEE Michael P. Kitta M00348			
22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Rockville, Inc., 300 W. Montgomery Ave Rockville, Maryland 20850-2805				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → SEPTICEMIA Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PARKINSONS DISEASE MULTIPLE DECUBITUS ULCER DYSPHASIA			
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) 10/11/94			
28b. TIME OF INJURY M				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER Ra Ishanaga, MD				29c. LICENSE NUMBER D20108			
29d. DATE SIGNED (Month, Day, Year) 10/18/94				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RAKESH AROPA, MD 14300 GALLANT FOX LN, BOWIE MD 20715			
31. DATE FILED (Month, Day, Year) OCT 24 1994				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Page 8 may be retained by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 9 may be retained by the funeral director.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 8 may be retained by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 9 may be retained by the funeral director.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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ITEMS: 28a-f, PER MEO FILM G-726 8/28/95-t-t

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) GREGORY P. WORDEN				2. DATE OF DEATH MONTH DAY YEAR October 24, 1994		3. TIME OF DEATH 1951	
4. SOCIAL SECURITY NUMBER 222-54-6561		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 34 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 20, 1960	
8. BIRTHPLACE (State or Foreign Country) Delaware				9a. FACILITY NAME (If not institution, give street and number) 400 Block of Leeds Road		9b. CITY, TOWN OR LOCATION OF DEATH Elkton	
9c. COUNTY OF DEATH Cecil				10a. STATE Maryland		10b. COUNTY Cecil	
10c. CITY, TOWN OR LOCATION Elkton				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 60 Matthew Bathon Drive	
10f. ZIP CODE 21921				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Teacher		16b. KIND OF BUSINESS/INDUSTRY Education			
17. FATHER'S NAME (First, Middle, Last) Dexter Worden				18. MOTHER'S NAME (First, Middle, Maiden Surname) Shirley J. Wood			
19a. INFORMANT'S NAME (Type/Print) Lynn J. Worden				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 60 Matthew Bathon Drive - Elkton, MD 21921			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) R.A. Ferris & Company		20c. LOCATION — City or Town, State 10-26 1994 West Chester, PA		21. SIGNATURE OF FUNERAL SERVICE LICENSEE Donald S. Hicks	
22. NAME AND ADDRESS OF FACILITY Hicks Home for Funerals, P.A. 103 West Stockton Street Elkton, MD 21921-5521		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. Carbon Monoxide Poisoning DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO						DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) 400 Blk. Leeds Road					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input checked="" type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide		28a. DATE OF INJURY (Month, Day, Year) OCT. 24, 1994		28b. TIME OF INJURY UNK.		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURED INHALED EXHAUST FUMES FROM AUTO		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) ROAD		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) LEEDS RD. ELKTON, MD.			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Peter Stavrakis, M.D.				29c. LICENSE NUMBER D/2192		29d. DATE SIGNED (Month, Day, Year) 10/26/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Peter Stavrakis, M.D. - Union Hospital of Cecil County - Elkton, MD 21921							
31. DATE FILED (Month, Day, Year) OCT 28 '94		32. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit form to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33710

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Cherrie Ward		2. DATE OF DEATH MONTH 10 DAY 18 YEAR 94		3. TIME OF DEATH 20:40 PM	
4. SOCIAL SECURITY NUMBER 579-24-8025		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 87 YRS.	
7. DATE OF BIRTH (Month, Day, Year) December 25 1906		8. BIRTHPLACE (State or Foreign Country) North Carolina			
9a. FACILITY NAME (If not institution, give street and number) Washington Adventist Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Takoma Park		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT					
10a. STATE Maryland		10b. COUNTY Prince Georges		10c. CITY, TOWN OR LOCATION Chillum	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER 1106 Burketon Road		10f. ZIP CODE 20783		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: Black					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 years		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Licensed Practical Nurse		16b. KIND OF BUSINESS/INDUSTRY Hospitals	
17. FATHER'S NAME (First, Middle, Last) Austin Ward		18. MOTHER'S NAME (First, Middle, Maiden Surname) Carrie Ward			
19a. INFORMANT'S NAME (Type/Print) Catherine Ward Taylor (daughter)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1106 Burketon Road, Chillum, Maryland 20783			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Cemetery		20c. LOCATION — City or Town, State Brentwood, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Corral Keith-Solomon		22. NAME AND ADDRESS OF FACILITY Latney's Funeral Home 3831 Georgia Avenue, N.W.; Wash. D.C. 20011			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Respiratory Failure Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Septecoma and c. Pneumonia and d. Heart Failure					Approximate Interval Between Onset and Death 3-4 Days 30 Days 30 Days 15 Days
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Multiple infected Decubitus					24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER M Karim MD		29c. LICENSE NUMBER D-18895		29d. DATE SIGNED (Month, Day, Year) 10-19-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MOBARAK KARIM, 7610 CARROLL AVENUE, TAKOMA PARK, MD					
31. DATE FILED (Month, Day, Year) OCT 27 1994		32. REGISTRAR'S SIGNATURE Jeha Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33711

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) HARRY WEISS				2. DATE OF DEATH MONTH DAY YEAR 10-19-94		3. TIME OF DEATH 7:10 A M	
4. SOCIAL SECURITY NUMBER 220-42-2162		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		8. AGE (In yrs. last birthday) 87 YRS.		7. DATE OF BIRTH (Month, Day, Year) 08-28-07	
9a. FACILITY NAME (If not institution, give street and number) COLLINGTON EPISCOPAL LIFE CTR.				9b. CITY, TOWN OR LOCATION OF DEATH Mitchellville		9c. COUNTY OF DEATH Prince Georges	
10a. STATE Maryland				10b. COUNTY Prince Georges		10c. CITY, TOWN OR LOCATION Mitchellville	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 10450 Lottsford Road			
10f. ZIP CODE 20721				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5 +		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Economist		16b. KIND OF BUSINESS/INDUSTRY U.S. Dept. of Labor			
17. FATHER'S NAME (First, Middle, Last) Samuel Weiss				18. MOTHER'S NAME (First, Middle, Maiden Surname) Esther			
19a. INFORMANT'S NAME (Type/Print) Gertrude Weiss				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10450 Lottsford Road Mitchellville, MD 20721			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 10120 Alexandria, VA		20c. LOCATION — City or Town, State MD		20d. DATE 10-20-94	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Julia P. Marshall				22. NAME AND ADDRESS OF FACILITY Marshall's Funeral Home, Inc. 4308 Suitland Rd. Suitland, MD 20746			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): b. Parkinson's DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Approximate Interval Between Onset and Death months months							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Marie A. Dobyns				29c. LICENSE NUMBER D29923		29d. DATE SIGNED (Month, Day, Year) 10-20-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Marie A. Dobyns, M.D. 7443 Hanover Pkwy. Greenbelt, MD 20770							
31. DATE FILED (Month, Day, Year) OCT 25 1994		32. REGISTRAR'S SIGNATURE Julia Davidson-Rendell					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33712

AMENDED # 19a, 10/25/94, CYW, P.G. COUNTY

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) PHILIP DONALD WILLIAMS				2. DATE OF DEATH OCT 14 1994		3. TIME OF DEATH 6:45 AM	
4. SOCIAL SECURITY NUMBER 046-24-0155		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 70 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 5, 1924	
9a. FACILITY NAME (If not institution, give street and number) 7662 NORTH ARBORY DRIVE				9b. CITY, TOWN OR LOCATION OF DEATH LAUREL		9c. COUNTY OF DEATH P.G.	
10a. STATE MD		10b. COUNTY PRINCE GEORGES		10c. CITY, TOWN OR LOCATION LAUREL		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 7662 NORTH ARBORY DRIVE				10f. ZIP CODE 20707		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 years		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) PHOTOGRAPHER		16b. KIND OF BUSINESS/INDUSTRY FEDERAL GOVERNMENT			
17. FATHER'S NAME (First, Middle, Last) GEORGE F. WILLIAMS				18. MOTHER'S NAME (First, Middle, Maiden Surname) ANNA ELIZABETH			
19a. INFORMANT'S NAME (Type/Print) LEVERNE Y. WILLIAMS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7662 NORTH ARBORY DR. LAUREL, MD. 20707			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ARLINGTON NATIONAL CEM. 10/20/94		20c. LOCATION — City or Town, State ARLINGTON, VA.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Bilva J. Jenkins				22. NAME AND ADDRESS OF FACILITY JOHNSON & JENKINS INC. 716 KENNEDY ST., N.W. WASHINGTON, DC @			
23. PART I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → coronary artery disease DUE TO (OR AS A CONSEQUENCE OF): Hypertensive arteriosclerotic cardiac-vascular disease Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): chronic obstructive pulmonary disease							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. chronic obstructive pulmonary disease						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) X <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER W. J. Vallejo MD				29c. LICENSE NUMBER D12879		29d. DATE SIGNED (Month, Day, Year) Oct 15 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ARLONSO VALLEJO M.D. 10701 TRAFALGAR DR. LAUREL MD 20772							
31. DATE FILED (Month, Day, Year) OCT 25 1994				32. REGISTRAR'S SIGNATURE Gina Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

... ..



[Handwritten text, possibly a signature or date, located in the bottom right corner.]

94 33713

1 FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) VIOLA MAE WARNER				2. DATE OF DEATH MONTH DAY YEAR OCT 20 1994		3. TIME OF DEATH 1:00 A	
4. SOCIAL SECURITY NUMBER 227-48-9701		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 56 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb 6, 1938	
8. BIRTHPLACE (State or Foreign Country) Virginia				9a. CITY, TOWN OR LOCATION OF DEATH Bethesda, MD		9b. COUNTY OF DEATH Montgomery	
10. RESIDENCE OF DECEDENT							
10a. STATE N/A		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Washington DC		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 649 Park Road				10f. ZIP CODE 20010-2507		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Domestic		16b. KIND OF BUSINESS/INDUSTRY Domestic			
17. FATHER'S NAME (First, Middle, Last) James P. Tibbs				18. MOTHER'S NAME (First, Middle, Maiden Surname) Helen Johnson			
19a. INFORMANT'S NAME (Type/Print) Helen Johnson Tibbs				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20470 Black Jack Rd. Culpeper Va. 22701			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, institution or other place) Culpeper National Cem 10/24/94 Culpeper Va.		20c. LOCATION — City or Town, State WC Thompson FH		20d. ADDRESS OF FACILITY 503-7 N. Main St Culpeper Va 22701	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Roger J. Mason</i>				22. NAME AND ADDRESS OF FACILITY WC Thompson FH 503-7 N. Main St Culpeper Va 22701			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ASPIRATION PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF): SMALL CELL LUNG CANCER DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST SMALL CELL LUNG CANCER DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death 1 WK 18 MONTHS
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jeffrey B Cole MD</i>				29c. LICENSE NUMBER D-45582		29d. DATE SIGNED (Month, Day, Year) Oct 20, 94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. B. COLE, LCDR, MC, USN				31. DATE FILED (Month, Day, Year) OCT 27 1994			
32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1913

ALBERT W. BROWN

RECEIVED

5

ALBERT W. BROWN

RECEIVED

94 33714

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ELMO ODELL WALKER				2. DATE OF DEATH MONTH DAY YEAR 10 22 94		3. TIME OF DEATH 6:17PM M	
4. SOCIAL SECURITY NUMBER 224-34-5872		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 66 YRS.	7. DATE OF BIRTH (Month, Day, Year) APRIL 10, 1928		8. BIRTHPLACE (State or Foreign Country) VIRGINIA	
9a. FACILITY NAME (If not institution, give street and number) PRINCE GEORGE'S HOSPITAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH CHEVERLY		9c. COUNTY OF DEATH PRINCE GEORGE'S	
10a. STATE MARYLAND				10b. COUNTY PRINCE GEORGE'S		10c. CITY, TOWN OR LOCATION CHAPEL OAKS	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER 4912 NASH STREET				10f. ZIP CODE 20743		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 3rd		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) MECHANIC		15b. KIND OF BUSINESS/INDUSTRY PRIVATE			
17. FATHER'S NAME (First, Middle, Last) HAYWARD WALKER				18. MOTHER'S NAME (First, Middle, Maiden Surname) HARRIET WALKER			
19a. INFORMANT'S NAME (Type/Print) IDA WALKER (WIFE)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4912 NASH STREET, CHAPEL OAKS, MARYLAND 20743			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) CEDAR HILL CEMETERY 10/28/94		20c. LOCATION — City or Town, State SUITLAND, MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Juawana L. Braxton				22. NAME AND ADDRESS OF FACILITY J.B. JENKINS FUNERAL HOME 7474 LANDOVER RD, LANDOVER, MARYLAND 20785			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>MESENTERIC THROMBOSIS WITH SMALL INTESTINE INFECTION</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>PULMONARY EMBOLI</u> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death days
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Emergency laparotomy</u>							24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Richard P. Rodriguez MD				29c. LICENSE NUMBER 201230		29d. DATE SIGNED (Month, Day, Year) October 25, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Richard P. Rodriguez MD, 5809 Rayburn Ct Sp 5m Md 20748							
31. DATE FILED (Month, Day, Year) OCT 27 1994				32. REGISTRAR'S SIGNATURE James H. H. H.			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33715

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) BESSIE CATHERINE WINEBRENNER				2. DATE OF DEATH MONTH 10 , DAY 28 , YEAR 94		3. TIME OF DEATH 08:20 A M	
4. SOCIAL SECURITY NUMBER 216 22 5239		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) 3 30 1911	
9a. FACILITY NAME (If not institution, give street and number) SACRED HEART HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND		9c. COUNTY OF DEATH ALLEGANY	
10a. STATE Maryland		10b. COUNTY Garrett		10c. CITY, TOWN OR LOCATION Frostburg		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER Star Route Box 8				10f. ZIP CODE 21532		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMY FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) _____		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Seamstress		16b. KIND OF BUSINESS/INDUSTRY Clothing			
17. FATHER'S NAME (First, Middle, Last) Philip Baker				18. MOTHER'S NAME (First, Middle, Maiden Surname) Annie Miller			
19a. INFORMANT'S NAME (Type/Print) Francis Winebrenner				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Star Route Box 8 Frostburg, Maryland 21532			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Johnson Cemetery 10/30/94		20c. LOCATION — City or Town, State Finzel, Maryland		20d. DATE 10/30/94	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John R. Purcell</i>				22. NAME AND ADDRESS OF FACILITY Durst Funeral Home 57 Frost Avenue Frostburg, Md. 21532			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Renal failure DUE TO (OR AS A CONSEQUENCE OF): b. Hypertensive Renal Vascular Disease DUE TO (OR AS A CONSEQUENCE OF): c. Atherosclerosis DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary artery disease, Congestive Heart Failure, Cerebral artery disease, Hypertension						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>J. Sidhu</i>		29c. LICENSE NUMBER 12640		29d. DATE SIGNED (Month, Day, Year) 11/1/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HARJIT SIDHU, M.D. 925 BISHOP WALSH ROAD CUMBERLAND, MD. 21502							
31. DATE FILED (Month, Day, Year) NOV 01 1994		32. REGISTRAR'S SIGNATURE <i>John A. Randall</i>					

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33716

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) RUSSELL HENRY WEBER				2. DATE OF DEATH MONTH DAY YEAR OCTOBER 26 1994		3. TIME OF DEATH 5:15 AM	
4. SOCIAL SECURITY NUMBER 217-10-7220		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 91 YRS.		7. DATE OF BIRTH (Month, Day, Year) SEPT 25 1903	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9. FACILITY NAME (If not institution, give street and number) 1 BALTIMORE STREET KENSINGTON/ALGONQUIN CUMBERLAND			
10. STATE MARYLAND				10b. COUNTY ALLEGANY		10c. CITY, TOWN OR LOCATION CUMBERLAND	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER BALTIMORE STREET KENSINGTON/ALGONQUIN			
10f. ZIP CODE 21502				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) CONSTRUCTION SUPERINTENDENT		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CONSTRUCTION SUPERINTENDENT		16b. KIND OF BUSINESS/INDUSTRY CONSTRUCTION			
17. FATHER'S NAME (First, Middle, Last) LEWIS FRANKLIN WEBER				18. MOTHER'S NAME (First, Middle, Maiden Surname) ANNA M. SMITH			
19a. INFORMANT'S NAME (Type/Print) DONALD WEBER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 810 CALVIN STREET CUMBERLAND MARYLAND 21502			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) CUMBERLAND CREMATORY OCT 26 1994		20c. LOCATION — City or Town, State CUMBERLAND MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dale L. Merritt</i>				22. NAME AND ADDRESS OF FACILITY MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Coronary Artery Disease</i> DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Congestive Heart Failure</i>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER D-14865		29d. DATE SIGNED (Month, Day, Year) 10-26-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. ROBERTIANO J. BARRERA MEMORIAL HOSPITAL MEDICAL BUILDING CUMBERLAND MD.							
31. DATE FILED (Month, Day, Year) OCT 27 1994				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33717

1 FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Paul Mowbray Wingate				2. DATE OF DEATH MONTH DAY YEAR October 30, 1994		3. TIME OF DEATH 11:00 A M	
4. SOCIAL SECURITY NUMBER 220-26-1812		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 64 YRS.		7. DATE OF BIRTH (Month, Day, Year) 5/29/1930	
9a. FACILITY NAME (If not institution, give street and number) 14 Bay Heights Avenue				9b. CITY, TOWN OR LOCATION OF DEATH Cambridge		9c. COUNTY OF DEATH Dorchester	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Dorchester		10c. CITY, TOWN OR LOCATION Cambridge		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 14 Bay Heights Avenue				10f. ZIP CODE 21613		10g. CITIZEN OF WHAT COUNTRY? US	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Jan 1952 Jan 1954		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 11				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Mechanic		16b. KIND OF BUSINESS/INDUSTRY Chemical Co.	
17. FATHER'S NAME (First, Middle, Last) Mowbray H. Wingate				18. MOTHER'S NAME (First, Middle, Maiden Surname) Velma Woodland			
19a. INFORMANT'S NAME (Type/Print) Cindy L. Newcomb				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 135 Church Creek, Maryland 21622			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Md. Veterans Cemetery		20c. DATE 11-1		20d. LOCATION — City or Town, State Hurlock, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John T. Loper</i>				22. NAME AND ADDRESS OF FACILITY Thomas Funeral Home 700 Locust St. Cambridge, Maryland 21613			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Cardiopulmonary Arrest</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Lung Cancer</u> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death 4 Min 10 Months
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>William Bair</i>				29c. LICENSE NUMBER D43238		29d. DATE SIGNED (Month, Day, Year) 10/1/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) William Bair 19 Franklin St. Cambridge, MD 21613							
31. DATE FILED (Month, Day, Year) NOV 02 1994				32. REGISTRAR'S SIGNATURE <i>John D. Anderson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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94 33718

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Sterling E. Ward</i>				2. DATE OF DEATH MONTH <i>11</i> DAY <i>01</i> YEAR <i>94</i>		3. TIME OF DEATH <i>325 A</i> M	
4. SOCIAL SECURITY NUMBER <i>212-24-5177</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>66</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>12-3-1927</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i>				9a. FACILITY NAME (If not institution, give street and number) <i>Siani Hospital</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>	
9c. COUNTY OF DEATH <i>Baltimore</i>				10a. STATE <i>MD</i>		10b. COUNTY <i>Carroll</i>	
10c. CITY, TOWN OR LOCATION <i>Westminster</i>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <i>47 1/2 Liberty Street</i>	
10f. ZIP CODE <i>21157</i>				10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>8</i> College (1-4 or 5+) <i></i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Steel Worker</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Steel</i>	
17. FATHER'S NAME (First, Middle, Last) <i>Walter Ward</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>edna Krider</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Mary Ward</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>47 1/2 Liberty Street Westminster, Md 2117</i>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) <i>Carroll Cremation 11-2-94</i>		20c. LOCATION — City or Town, State <i>Hampstead, MD</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Katherine Potts - Switzer</i>				22. NAME AND ADDRESS OF FACILITY <i>Pritts Funeral Home 412 Washington Road Westminster</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Myocardial Infarction</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. <i>Anemia</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
c. <i>Peptic Ulcers</i>							
DUE TO (OR AS A CONSEQUENCE OF):							
d. <i>Diabetes Mellitus</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic Renal Failure, Cardio myopathy, Chronic obstructive pulmonary disease</i>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Michael Goldfine</i>				29c. LICENSE NUMBER <i>AS2402321-MA9823</i>		29d. DATE SIGNED (Month, Day, Year) <i>11/01/94</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Michael Goldfine, SIANI HOSPITAL</i>							
31. DATE FILED (Month, Day, Year) <i>NOV 03 1994</i>				32. REGISTRAR'S SIGNATURE <i>John A. Anderson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial certificate.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33719

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Alexander Willard</i>				2. DATE OF DEATH MONTH <i>10</i> DAY <i>20</i> YEAR <i>94</i>		3. TIME OF DEATH <i>0335 A.M.</i>	
4. SOCIAL SECURITY NUMBER <i>220 22 7974</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>64</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>11-14-29</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Anne Arundel Med Center</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Annapolis Md</i>		9c. COUNTY OF DEATH <i>Anne Arundel</i>	
10a. STATE <i>md</i>		10b. COUNTY <i>Anne Arundel Co</i>		10c. CITY, TOWN OR LOCATION <i>Annapolis</i>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>16 Bunche St</i>				10f. ZIP CODE <i>21401</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>BLACK</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>7th</i> College (1-4 or 5+) <i>LABORER</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>LABORER</i>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <i>WILLIAM WILLARD</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>ANNIE GILES</i>			
19a. INFORMANT'S NAME (Type/Print) <i>SARAH WILLARD</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>16 BUNCHE STREET ANNAPOLLIS, MD. 21401</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>ANNAPOLIS MEM. GARDENS 11/1/94</i>		20c. LOCATION — City or Town, State <i>ANNAPOLIS, MD. 21401</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Larry H. Reese</i>				22. NAME AND ADDRESS OF FACILITY <i>REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Coronary artery disease</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Atherosclerosis</i> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Diabetes mellitus type II</i>							Approximate Interval Between Onset and Death <i>Immediate</i> <i>Several years</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetes mellitus type II</i>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide					
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Charles W. Kinzer MD</i>				29c. LICENSE NUMBER <i>D05928</i>		29d. DATE SIGNED (Month, Day, Year) <i>Oct 29, 1994</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Charles W. Kinzer, MD, 1833 Forest Drive, Annapolis, MD</i>							
31. DATE FILED (Month, Day, Year) <i>NOV 03 1994</i>		32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0062

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33720

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Jane Katherine Young				2. DATE OF DEATH MONTH DAY YEAR October 23 1994		3. TIME OF DEATH 9:12P M	
4. SOCIAL SECURITY NUMBER 578-42-2372		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 29 1916	
8. BIRTHPLACE (State or Foreign Country) Washington, DC				9. COUNTY OF DEATH Anne Arundel			
9a. FACILITY NAME (If not institution, give street and number) Anne Arundel Medical Center				9b. CITY, TOWN OR LOCATION OF DEATH Annapolis		9c. COUNTY OF DEATH Anne Arundel	
10a. STATE MD				10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Crofton	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 2131 Davidsonville Road			
10f. ZIP CODE 21114				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary		16b. KIND OF BUSINESS/INDUSTRY Architecture Firms			
17. FATHER'S NAME (First, Middle, Last) Henry C. Lybrand				18. MOTHER'S NAME (First, Middle, Maiden Surname) Flora Ferguson			
19a. INFORMANT'S NAME (Type/Print) Peter Young				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 817 Vine Street Crownsville, Maryland 21032			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery or other place) Lincoln Cemetery 10/31/94		20c. LOCATION — City or Town, State Brentwood, Maryland		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donald S. Lybrand</i>	
22. NAME AND ADDRESS OF FACILITY John M. Taylor Funeral Home 147 Duke of Gloucester st. Annapolis, MD				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>CARDIAC ARRHYTHMIA</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>ATRIAL FIBRILLATION</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>CONGESTIVE HEART FAILURE</u> DUE TO (OR AS A CONSEQUENCE OF): d. <u>10/31/94</u> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input checked="" type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED					
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Susan H. Krieger, MD</i>				29c. LICENSE NUMBER D44838		29d. DATE SIGNED (Month, Day, Year) 10-30-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SUSAN KRIEGER, MD OWENSVILLE MEDICAL CENTER							
31. DATE FILED (Month, Day, Year) 10-30-NOV 1 1994				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LEWIS FRANKIE BROWN JR.				2. DATE OF DEATH MONTH 11 DAY 09 YEAR 94		3. TIME OF DEATH 11:30 P M	
4. SOCIAL SECURITY NUMBER 212-54-7748		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 44 YRS.		7. DATE OF BIRTH (Month, Day, Year) 7-28-50	
8. BIRTHPLACE (State or Foreign Country) BALTO. MD.				9a. FACILITY NAME (If not institution, give street and number) SINAI HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE	
9c. COUNTY OF DEATH MARYLAND				10a. STATE MARYLAND		10b. COUNTY BALTIMORE	
10c. CITY, TOWN OR LOCATION BALTIMORE				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 609 BENNINGHAUS RD.	
10f. ZIP CODE 21212				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary <input type="checkbox"/> Secondary (9-12) <input checked="" type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) WELDER		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) LEWIS F. BROWN SR.				18. MOTHER'S NAME (First, Middle, Maiden Surname) DORA V. HILL (SMITH)			
19a. INFORMANT'S NAME (Type/Print) DORA V. HILL				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 609 BENNINGHAUS RD. BALTIMORE, MD. 21212			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT. ZION		20c. LOCATION — City or Town, State 11-16 BALTO. MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY WILLIAM C. BROWN COMM. F.H. 1206 W. NORTH AVE. BALTO. MD.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MULTI-SYSTEM ORGAN FAILURE SECONDARY TO SEPSIS 10/31 - 11/09 b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER AJ4147357		29d. DATE SIGNED (Month, Day, Year) 11/09/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DREW M. HORLBECK SINAI HOSPITAL							
31. DATE FILED (Month, Day, Year) NOV 16 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARY T. BROWN				2. DATE OF DEATH MONTH Nov. DAY 13 YEAR 1994		3. TIME OF DEATH 7:40 P.M.	
4. SOCIAL SECURITY NUMBER 212-18-2084		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 75 YRS.	7. DATE OF BIRTH (Month, Day, Year) Sept. 12, 1919		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) 3310 Trellis Lane				9b. CITY, TOWN OR LOCATION OF DEATH Abingdon		9c. COUNTY OF DEATH Harford	
10a. STATE Maryland				10b. COUNTY Harford		10c. CITY, TOWN OR LOCATION Abingdon	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 3310 Trellis Lane				10f. ZIP CODE 21009		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Store Owner		16b. KIND OF BUSINESS/INDUSTRY Browns Confectionary Store			
17. FATHER'S NAME (First, Middle, Last) Pasquale Celozzi				18. MOTHER'S NAME (First, Middle, Maiden Surname) Palma Cannelli			
19a. INFORMANT'S NAME (Type/Print) Robert Brown				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 205 Archer Street Bel Air Md. 21014			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Md. Veterans Cemetery 11-17		20c. LOCATION — City or Town, State Crownsville, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Joseph N. Zannino Jr. Funeral Home 263 S. Conkling St. Balto. Md. 21224			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → glioblastoma of the brain DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D32783		29d. DATE SIGNED (Month, Day, Year) 11/16/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Joseph Adams M.D. 7401 Osler Drive Baltimore, Maryland 21204							
31. DATE FILED (Month, Day, Year) NOV 16 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Item 19b, g-717, 11-16-94, per F.H., dr
 FOR
 1 - STATE REGISTRAR
 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH
 REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Robert Browning				2. DATE OF DEATH MONTH 11 DAY 10 YEAR 94		3. TIME OF DEATH 14 34 M	
4. SOCIAL SECURITY NUMBER 415-54-7835		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 65 YRS.		7. DATE OF BIRTH (Month, Day, Year) 6/28/29	
9a. FACILITY NAME (If not institution, give street and number) University Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City		9c. COUNTY OF DEATH N/A	
10a. STATE MD				10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 924 Cherry Hill Rd.			
10f. ZIP CODE 21225				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 TH College (1-4 or 5+) —		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) PIPE FITTER		16b. KIND OF BUSINESS/INDUSTRY (BETHLEHEM STEEL/CALCUMET STEEL MILL			
17. FATHER'S NAME (First, Middle, Last) LEROY BROWNING				18. MOTHER'S NAME (First, Middle, Maiden Surname) LEONA CREAVES			
19a. INFORMANT'S NAME (Type/Print) REX ELDERER BROWNING				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 742 W. 104 STREET, LOS ANGELES, CA 90044			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Carroll Forest Cemetery		DATE 11-17		20c. LOCATION — City or Town, State Owings Mills, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Theresa Cook				22. NAME AND ADDRESS OF FACILITY WM C HARTZ FH - 1101 E North Ave.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sepsis a. DUE TO (OR AS A CONSEQUENCE OF): Bilateral Lower Leg Gangrene b. DUE TO (OR AS A CONSEQUENCE OF): Peripheral Vascular Disease c. DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Henry Silverman MD				29c. LICENSE NUMBER 022643		29d. DATE SIGNED (Month, Day, Year) 11/16/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HENRY SILVERMAN, MD							
31. DATE FILED (Month, Day, Year) NOV 16 1994				32. REGISTRAR'S SIGNATURE [Signature]			

94 33724

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) EDWARD F. BENJAMIN				2. DATE OF DEATH MONTH DAY YEAR NOVEMBER 11, 1994		3. TIME OF DEATH n/a M	
4. SOCIAL SECURITY NUMBER 212-12-4600		5. SEX XX <input type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) MAY 15, 1916	
8. BIRTHPLACE (State or Foreign Country) S. CAROLINA							
9a. FACILITY NAME (If not institution, give street and number) 2223 AISQUITH STREET				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH n/a	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY n/a		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 2223 AISQUITH STREET				10f. ZIP CODE 21218		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 TH College (13-16) -				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) TRUCK DRIVER		16b. KIND OF BUSINESS/INDUSTRY HYGRADE + MEAT PACKING COMPANY	
17. FATHER'S NAME (First, Middle, Last) MOSES BENJAMIN				18. MOTHER'S NAME (First, Middle, Maiden Surname) ETTA SHIELDS			
19a. INFORMANT'S NAME (Type/Print) MATTIE P. BENJAMIN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2223 AISQUITH STREET, BALTIMORE, MD 21218			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) MD. NATIONAL CEMETERY		DATE 11-16		20c. LOCATION — City or Town, State LAUREL, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Karen M. Kozar				22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH AVENUE			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. CONGESTIVE HEART FAILURE DUE TO (OR AS A CONSEQUENCE OF): b. CARDIOMYOPATHY DUE TO (OR AS A CONSEQUENCE OF): c. CORONARY ARTERY DISEASE DUE TO (OR AS A CONSEQUENCE OF): d. HYPERTENSION							
Approximate Interval Between Onset and Death 1 DAY 2 YEARS 2 YEARS 5 YEARS							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER James J. MD				29c. LICENSE NUMBER L4799		29d. DATE SIGNED (Month, Day, Year) 11/15/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOHNS HOPKINS HOSPITAL, 600 N. WOLFE ST, BALTIMORE, MD 21205							
31. DATE FILED (Month, Day, Year) NOV 16 1994				32. REGISTRAR'S SIGNATURE James J. Registrar			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33725

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Theresa Bretzik				2. DATE OF DEATH MONTH DAY YEAR November 13, 1994		3. TIME OF DEATH 1:53 P. M.	
4. SOCIAL SECURITY NUMBER 197-24-8483		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 62 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 11, 1932	
9a. FACILITY NAME (If not institution, give street and number) Good Samaritan Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore, City		9c. COUNTY OF DEATH Penna.	
10a. STATE Maryland				10b. COUNTY Baltimore, City		10c. CITY, TOWN OR LOCATION Baltimore, City	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 6519 Alta Ave.			
10f. ZIP CODE 21206				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 3 College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Registered Nurse		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) Michael Mikovich				18. MOTHER'S NAME (First, Middle, Maiden Surname) Esther Ferko			
19a. INFORMANT'S NAME (Type/Print) Thomas Bretzik				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as 10e			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Marys Catholic Cem. 11/16/94		20c. LOCATION — City or Town, State Nesquehoning, Pa.		22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck Funeral Home, Inc. 5305 Harford Rd. Balto. Md. 21214	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donald E. Schaefer</i>				23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>acute infarct: Arteriosclerotic Heart Disease</i> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death: <i>hours</i>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypertension</i> <i>Hypertension</i>				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accidental 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Shelly N. Thamm</i>		29c. LICENSE NUMBER D2859	
29d. DATE SIGNED (Month, Day, Year) 11/14/94				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Phillip Moore M.D. 5601 Loch Raven Blvd. Balto. Md. 21239			
31. DATE FILED (Month, Day, Year) NOV 16 1994				32. REGISTRAR'S SIGNATURE <i>John E. Anderson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

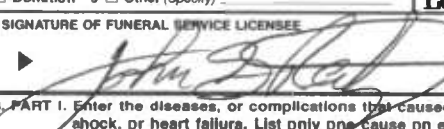
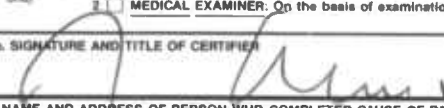
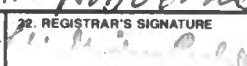
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33726

Item 20c, Film 717, 11/16/94, 1t

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ETTA Tatum Bittorf				2. DATE OF DEATH MONTH Nov DAY 13 YEAR 1994		3. TIME OF DEATH 9:30 A.M.	
4. SOCIAL SECURITY NUMBER 213-74-9416		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 94 YRS.		7. DATE OF BIRTH (Month, Day, Year) August 11, 1900	
9a. FACILITY NAME (If not institution, give street and number) Edenwald, 800 Southerly Road #1215		9b. CITY, TOWN OR LOCATION OF DEATH Towson		9c. COUNTY OF DEATH Baltimore			
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Towson		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 800 Southerly Road #1215 Edenwald				10f. ZIP CODE 21286		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) Homemaker		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) James Edward Tatum				18. MOTHER'S NAME (First, Middle, Maiden Surname) Dorothea Seibel			
19a. INFORMANT'S NAME (Type/Print) Henry J.W. Bittorf				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1338 Walker Avenue, Baltimore, Maryland 21239-1703			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Loudon Park		DATE Nov 16		20c. LOCATION — City or Town, State Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home 6500 York Rd. Baltimore, Maryland 21212					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Atherosclerotic Cardiovascular disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. Hypothyroidism DUE TO (OR AS A CONSEQUENCE OF): c. Essential tremors DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death 20 yr 10 yr 30 yr
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  physician				29c. LICENSE NUMBER D29709		29d. DATE SIGNED (Month, Day, Year) 11/14/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) Marcelino D. Albuerne 4015 16th Alley Rd Brkts.							
31. DATE FILED (Month, Day, Year) NOV 16 1994		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) WILLARD BURNS				2. DATE OF DEATH MONTH NOV DAY 12TH YEAR 1994		3. TIME OF DEATH 8:40 A M	
4. SOCIAL SECURITY NUMBER 217-14-3606		5. SEX XX M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 91 YRS.		7. DATE OF BIRTH (Month, Day, Year) August 12, 1903	
9a. FACILITY NAME (If not institution, give street and number) Good Samaritan Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH N/A	
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Towson		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 5 Fellowship Ct				10f. ZIP CODE 21204		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Assistant Vice President		16b. KIND OF BUSINESS/INDUSTRY Banking			
17. FATHER'S NAME (First, Middle, Last) William H. Burns Jr				18. MOTHER'S NAME (First, Middle, Maiden Surname) Bessie Johnson			
19a. INFORMANT'S NAME (Type/Print) Julia Thorweger				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7047 Bissonnett #81 Houston, Texas 77074			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Loudon Park Cemetery		DATE 11/15		20c. LOCATION — City or Town, State Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ACUTE MYOCARDIAL INFARCTION THREE WEEKS Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. SEVERE PSEUDOMEMBRANOUS COLITIS c. PNEUMONIA d. HYPERTENSION							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> , M.D.				29c. LICENSE NUMBER P-07618		29d. DATE SIGNED (Month, Day, Year) NOV-12TH 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) KOFI OWUSU-BOATENG, GOOD SAMARITAN HOSP.							
31. DATE FILED (Month, Day, Year) NOV 16 1994				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33728

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Anne Elizabeth Carter						2. DATE OF DEATH NOV. 14, 1994		3. TIME OF DEATH M		
4. SOCIAL SECURITY NUMBER 219-10-2066		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 68 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 13, 1926		8. BIRTHPLACE (State or Foreign Country) Maryland		
9a. FACILITY NAME (If not institution, give street and number) 1014 Cord Street				9b. CITY, TOWN OR LOCATION OF DEATH Middle River			9c. COUNTY OF DEATH Baltimore			
RESIDENCE OF DECEDENT										
10a. STATE Md.		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Middle River				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 1014 Cord Street				10f. ZIP CODE 21220			10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) College (1-4 or 5+) 2yrs				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Medical Clerk			16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) William Pruitt					18. MOTHER'S NAME (First, Middle, Maiden Surname) Clara Nelson					
19a. INFORMANT'S NAME (Type/Print) Virginia Metcalf					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1014 Cord Street Baltimore Md. 21220					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gardens of Faith 11/17/94			20c. LOCATION — City or Town, State Rossville Md.				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE B. Terry Connelly					22. NAME AND ADDRESS OF FACILITY Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic breast Cancer DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.									Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)					28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER Kathleen Tharion						29c. LICENSE NUMBER D36146		29d. DATE SIGNED (Month, Day, Year) 11-14-94		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) UNIV. OF MARYLAND CANCER CTR, 22 SOUTH GREENE ST BALTIMORE										
31. DATE FILED (Month, Day, Year) NOV 16 1994			32. REGISTRAR'S SIGNATURE John Benson-Randall							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33729

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Nancy Crockett				2. DATE OF DEATH MONTH 11 DAY 13 YEAR 94		3. TIME OF DEATH 1250 P M	
4. SOCIAL SECURITY NUMBER 227-84-2924		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 52 YRS.		7. DATE OF BIRTH (Month, Day, Year) 5/6/42	
9a. FACILITY NAME (If not institution, give street and number) University Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH Va.	
10a. STATE Md.				10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Baltimore	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 2601 Molton Way			
10f. ZIP CODE 21244				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) 9		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Factory worker		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) Frank Savoy				18. MOTHER'S NAME (First, Middle, Maiden Surname) Corrine C. Boyd			
19a. INFORMANT'S NAME (Type/Print) Nettie Campbell				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2601 Molton Way Balto., Md. 21244			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT. ZION		DATE 11/19		20c. LOCATION — City or Town, State Balto., Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE James A. Molton				22. NAME AND ADDRESS OF FACILITY James A. Molton & Sons 1701 Laurens St. Balto., Md. 21217			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Brain Death DUE TO (OR AS A CONSEQUENCE OF): Left Intracerebral Hemorrhage DUE TO (OR AS A CONSEQUENCE OF): Brainstem Herniation DUE TO (OR AS A CONSEQUENCE OF): Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. PLACE OF DEATH (Check only one) OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER John O. Collins MD				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 11/13/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John O. Collins 22 S. Green St Baltimore Md 21201							
31. DATE FILED (Month, Day, Year) NOV 16 1994				32. REGISTRAR'S SIGNATURE John O. Collins			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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94 33730

Item 7, Film 717, 11/17/94, 1t

1 -
FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Dr. Nelson Stanley Covell				2. DATE OF DEATH MONTH DAY YEAR November 12, 1994		3. TIME OF DEATH 7:35 AM	
4. SOCIAL SECURITY NUMBER 218 12 0699		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 75 YRS.		7. DATE OF BIRTH (Month, Day, Year) August 8, 1919	
8. BIRTHPLACE (State or Foreign Country) Maryland				9. COUNTY OF DEATH Howard			
9a. FACILITY NAME (If not institution, give street and number) 575 Morgan Station Road				9b. CITY, TOWN OR LOCATION OF DEATH Woodbine		9c. COUNTY OF DEATH Howard	
10a. STATE Md.				10b. COUNTY Howard		10c. CITY, TOWN OR LOCATION Woodbine	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 575 Morgan Station Road				10f. ZIP CODE 21797		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) High School College (1-4 or 5+) +4				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Chiropractor		16b. KIND OF BUSINESS/INDUSTRY Chiropractic Care	
17. FATHER'S NAME (First, Middle, Last) Carroll Covell				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mabel E. Bell			
19a. INFORMANT'S NAME (Type/Print) Dorothy Marie Covell				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 575 Morgan Station Rd. Woodbine, Md. 21797			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Popular Springs Cemetery Nov. 15, 1994 Mt. Airy, Md.		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Harry W. Haight				22. NAME AND ADDRESS OF FACILITY Haight Funeral Home P.O. Box 195 Sykesville, Md. 21784			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → NOTASTATIC CA COCON Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]				29c. LICENSE NUMBER D-20452		29d. DATE SIGNED (Month, Day, Year) 11/14/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 1777 ROYAL STATION RD - BALTO, MD. 21208							
31. DATE FILED (Month, Day, Year) NOV 15 1994				32. REGISTRAR'S SIGNATURE [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

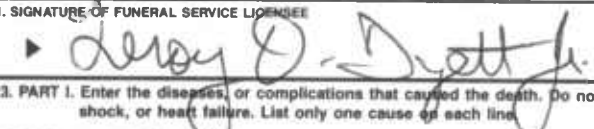
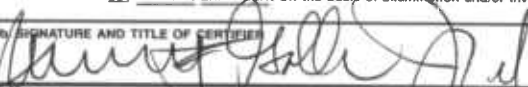
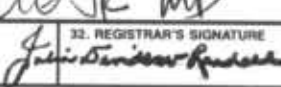
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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94 33731

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) SHIRLEY DANIELS				2. DATE OF DEATH MONTH 11 DAY 07 YEAR 94		3. TIME OF DEATH 18:41 P M	
4. SOCIAL SECURITY NUMBER 214-30-6818		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 60 YRS.	7. DATE OF BIRTH (Month, Day, Year) 07 06 34		8. BIRTHPLACE (State or Foreign Country) Balto. Md.	
9a. FACILITY NAME (If not institution, give street and number) 1831 N. Washington Street				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1831 N. Washington Street				10f. ZIP CODE 21213		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (13-16) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY N/A			
17. FATHER'S NAME (First, Middle, Last) John P. Hudson, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Gladys Hunt			
19a. INFORMANT'S NAME (Type/Print) Angelica Bomar				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1407 Lochner Road Apt. A. Balto. Md. 21239			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Baltimore Cemetery 11/12/94		20c. LOCATION — City or Town, State Baltimore, MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Leroy O. Dyett & Son Funeral Home, INC. 4600 Liberty Hgts Ave. Balto. Md. 21207			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → HEAD AND NECK INJURY DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. SEIZURE DISORDER AND ASTHMA							24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 11/07/94		28b. TIME OF INJURY 8:30 PM		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) HOME		28e. DESCRIBE NOW INJURY OCCURRED fell down the steps			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) 11/08/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARIO F. GOUGE JR MD 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) NOV 15 1994		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten text, possibly a signature or date, located near the bottom center of the page.

94 33732

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Clara Pat Ricks Davis				2. DATE OF DEATH MONTH DAY YEAR Oct 31, 1994		3. TIME OF DEATH 4:00 A ^M	
4. SOCIAL SECURITY NUMBER 217-54-2932		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) 42 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb 16, 1952	
9a. FACILITY NAME (If not institution, give street and number) University Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		8. BIRTHPLACE (State or Foreign Country) Maryland	
10a. STATE Maryland				10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Baltimore	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 2904 Belmont Avenue			
10f. ZIP CODE 21216				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) unknown		16b. KIND OF BUSINESS/INDUSTRY unknown			
17. FATHER'S NAME (First, Middle, Last) Bolden S. Ricks				18. MOTHER'S NAME (First, Middle, Maiden Surname) Leola Oliver			
19a. INFORMANT'S NAME (Type/Print) Karen Ricks				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2904 Belmont Avenue Baltimore, Maryland 21216			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory		20c. LOCATION — City or Town, State 11/4 catonsville, Maryland		20d. DATE 11/4	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, Inc 2501 Gwynns Falls Parkway Baltimore, Maryland 21216			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sepsis Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. HEPATIC ENCEPHALOPATHY c. AIDS d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER STANDIFORD					
29c. LICENSE NUMBER 045983		29d. DATE SIGNED (Month, Day, Year) 11/3/94					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) NOV 16 1994		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33733

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) WARREN C. DODA				2. DATE OF DEATH MONTH NOVEMBER DAY 15, 1994 YEAR				3. TIME OF DEATH 1:45PM M					
4. SOCIAL SECURITY NUMBER 218-26-4429		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 63 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) SEPTEMBER 7, 1931		8. BIRTHPLACE (State or Foreign Country) MARYLAND	
9a. FACILITY NAME (If not institution, give street and number) 1617 JOPLIN STREET						9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY				9c. COUNTY OF DEATH			
RESIDENCE OF DECEDENT													
10a. STATE MD		10b. COUNTY		10c. CITY, TOWN OR LOCATION BALTIMORE CITY				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
10e. STREET AND NUMBER 1617 JOPLIN STREET						10f. ZIP CODE 21224		10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES NAVY, 2/18/52-4/16/52		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH College (1-4 or 5+) _____				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) EXPEDITOR				16b. KIND OF BUSINESS/INDUSTRY U.S. POSTAL SERVICE					
17. FATHER'S NAME (First, Middle, Last) ALEXANDER DODA						18. MOTHER'S NAME (First, Middle, Maiden Surname) ANNA KUCZAK							
19a. INFORMANT'S NAME (Type/Print) KATHLEEN R. DODA						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1617 JOPLIN STREET, BALTIMORE, MARYLAND 21224							
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GREEN MOUNT CREMATORY (NOVEMBER 16, 94)				20c. LOCATION — City or Town, State BALTIMORE CITY					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John P. Doda</i>						22. NAME AND ADDRESS OF FACILITY CHARLES L. STEVENS FUNERAL HOME, INC. 1501 E. FORT AVENUE, BALTIMORE, MD 21230							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Impulsive heart failure</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>ischemic cardiomyopathy</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>Coronary heart disease</i> DUE TO (OR AS A CONSEQUENCE OF): d. _____ Approximate Interval Between Onset and Death <i>6 mo</i> <i>7 yrs</i> <i>15 yrs</i>													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John P. Doda MD</i>						29c. LICENSE NUMBER D10444		29d. DATE SIGNED (Month, Day, Year) 11/15/94					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) George C. ROVETI M.D. 100. N. BROADWAY, BALTO, Md. 21231													
31. DATE FILED (Month, Day, Year) NOV 16 1994				32. REGISTRAR'S SIGNATURE <i>John P. Doda</i>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33734

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) William Emminizer				2. DATE OF DEATH MONTH 11 DAY 14 YEAR 94		3. TIME OF DEATH 5:15 A M	
4. SOCIAL SECURITY NUMBER 216-01-9178		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 79 YRS.	7. DATE OF BIRTH MONTH 1 DAY 15 YEAR 1915		8. BIRTHPLACE (State or Foreign Country) MARYLAND	
9a. FACILITY NAME (If not institution, give street and number) J.H.B.V.M.C.				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE MD.		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION DUNDALK		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 1939 ORMAND ROAD				10f. ZIP CODE 21222		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Year or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) _____		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) MIXER		16b. KIND OF BUSINESS/INDUSTRY RUBER CO.			
17. FATHER'S NAME (First, Middle, Last) LOUIS EMMINIZER				18. MOTHER'S NAME (First, Middle, Maiden Surname) ADDIE WIESER			
19a. INFORMANT'S NAME (Type/Print) FRED A EMMINIZER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1939 ORMAND ROAD, DUNDALK, MD. 21222			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GREEN MT. CREMATORY 11/15		DATE 11/15		20c. LOCATION — City or Town, State BALTIMORE, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Edison M. Perkins D 00083				22. NAME AND ADDRESS OF FACILITY BRADLEY-ASHTON FUNERAL HOME INC. 2134 WILLOW SPRING RD. DUNDALK, MD.			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiac Arrest DUE TO (OR AS A CONSEQUENCE OF): a. Closed Head injury: subarachnoid hemorrhage DUE TO (OR AS A CONSEQUENCE OF): b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Approximate Interval Between Onset and Death 21 hrs 21 hrs							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 11-13-94		28b. TIME OF INJURY 8:00 AM		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) home				28d. DESCRIBE HOW INJURY OCCURRED fell down 6 steps			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 1939 Ormand Rd Dundalk MD				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER J.A. Sosa MD.				29c. LICENSE NUMBER JH M1012 A54147357		29d. DATE SIGNED (Month, Day, Year) 11/14/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J.A. Sosa MD.				31. DATE FILED (Month, Day, Year) NOV 16 1994			
32. REGISTRAR'S SIGNATURE John Benison-Randall							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Released on Approval by Medical Examiner 11-14-94 11:57am

U.S.A.

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ADDIE WIESER

LOUIS EMMINIZER

1939 ORMAND ROAD, DUNDALK,

FREDA EMMINIZER

X

2134 WILLOW ST
BRADLEY-ASTON
EDISON M. PERKINS
GREEN MT. CREMATORY 11/15

Edison M. Perkins

94 33735

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Michael Fratta				2. DATE OF DEATH MONTH DAY YEAR Nov. 13 1994		3. TIME OF DEATH M M	
4. SOCIAL SECURITY NUMBER 216-03-0628		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		8. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 5, 1916	
9a. FACILITY NAME (If not institution, give street and number) 616 Hyde Park Road				9b. CITY, TOWN OR LOCATION OF DEATH Essex		9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT							
10a. STATE Md.		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Essex		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 616 Hyde Park Road				10f. ZIP CODE 21221		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Foreman		16b. KIND OF BUSINESS/INDUSTRY Automobile			
17. FATHER'S NAME (First, Middle, Last) Theodore Fratta				18. MOTHER'S NAME (First, Middle, Maiden Surname) Erma ==			
19a. INFORMANT'S NAME (Type/Print) Michael L. Fratta				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1221 South Clinton Street Balto.Md. 21224			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MetroCrematory Inc. 11/14/94 Baltimore Md.		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE B. Terry Connolly				22. NAME AND ADDRESS OF FACILITY Connolly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Lung Cancer DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Dr. Stromberg				29c. LICENSE NUMBER 032543		29d. DATE SIGNED (Month, Day, Year) 11/15/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Stromberg 7505 Olser Drive Towson Md.							
31. DATE FILED (Month, Day, Year) NOV 16 1994				32. REGISTRAR'S SIGNATURE John S. ...			

TO BE COMPLETED BY FUNERAL DIRECTOR

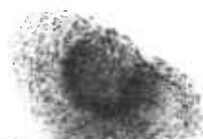
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33736

Item#2 Per F.H. Film# G-719 01/06/95 R.M.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Robert R. Griffin				2. DATE OF DEATH MONTH 10 DAY 14 YEAR 94		3. TIME OF DEATH 1155 A	
4. SOCIAL SECURITY NUMBER 712-09-5812		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) MAY 11, 1911	
8. BIRTHPLACE (State or Foreign Country) IOWA		9a. FACILITY NAME (If not institution, give street and number) LAUREL REGIONAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH LAUREL		9c. COUNTY OF DEATH PRINCE GEORGE	
10a. STATE MARYLAND		10b. COUNTY HOWARD		10c. CITY, TOWN OR LOCATION LAUREL		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 8428 JANDY AVENUE				10f. ZIP CODE 20723		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) STATION MASTER		16b. KIND OF BUSINESS/INDUSTRY RAILROAD			
17. FATHER'S NAME (First, Middle, Last) ROBERT H. GRIFFIN				18. MOTHER'S NAME (First, Middle, Maiden Surname) JOSEPHINE CLARK			
19a. INFORMANT'S NAME (Type/Print) JAMES GRIFFIN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8428 JANDY AVENUE, LAUREL, MARYLAND 20723			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BALTIMORE-WASHINGTON CREM		20c. LOCATION — City or Town, State LAUREL, MARYLAND		20d. DATE 10-15-94	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY FLECK FUNERAL HOME, INC. 7601 SANDY SPRING ROAD, LAUREL, MD 20707			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Septicemia DUE TO (OR AS A CONSEQUENCE OF): b. Secret Abscess DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER William A. Warren MD				29c. LICENSE NUMBER D13916		29d. DATE SIGNED (Month, Day, Year) 10-15-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) William A. Warren 321 Prince George St Laurel, MD 20707							
31. DATE FILED (Month, Day, Year) NOV 16 1994		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33737

Items 10 b & e, g-717, 11-16-94, per F.H., dr

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>William Garrett</u>				2. DATE OF DEATH MONTH <u>11</u> DAY <u>12</u> YEAR <u>94</u>		3. TIME OF DEATH <u>11:40 P.M.</u>	
4. SOCIAL SECURITY NUMBER <u>458-52-1664</u>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>62</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>MAR 19, 1932</u>	
8. BIRTHPLACE (State or Foreign Country) <u>FLORIDA</u>				9a. FACILITY NAME (If not institution, give street and number) <u>LAUREL REGIONAL HOSPITAL</u>		9b. CITY, TOWN OR LOCATION OF DEATH <u>LAUREL</u>	
9c. COUNTY OF DEATH <u>PRINCE GEORGE</u>				10a. STATE <u>MARYLAND</u>		10b. COUNTY <u>PRINCE GEORGE</u>	
10c. CITY, TOWN OR LOCATION <u>LAUREL</u>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <u>11803 BIGNONIA TERRACE</u>	
10f. ZIP CODE <u>20708</u>				10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>WHITE</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>8</u>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>MINISTER</u>		16b. KIND OF BUSINESS/INDUSTRY <u>BAPTIST CHURCH</u>	
17. FATHER'S NAME (First, Middle, Last) <u>WILLIAM E. GARRETT</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>EVELYN WEATHERFORD</u>			
19a. INFORMANT'S NAME (Type/Print) <u>LAURA GARRETT</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>11803 BIGNONIA TERRACE, LAUREL, MARYLAND 20708</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>MEMORIAL GARDEN PARK</u>		20c. LOCATION — City or Town, State <u>11/18 STARKVILLE, MISSISSIPPI</u>		20d. DATE <u>11/18</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>[Signature]</u>				22. NAME AND ADDRESS OF FACILITY <u>FLECK FUNERAL HOME, INC.</u> <u>7601 SANDY SPRING ROAD, LAUREL, MD 20707</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Myocardial Infarction</u> DUE TO (OR AS A CONSEQUENCE OF): b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>[Signature]</u>				29c. LICENSE NUMBER <u>D25430</u>		29d. DATE SIGNED (Month, Day, Year) <u>11/13/94</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>John MARGOLIS 14333 Laurel-Bowie Rd #307 Laurel, MD 20707</u>							
31. DATE FILED (Month, Day, Year) <u>NOV 16 1994</u>				32. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as a burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33738

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Morris Griffin				2. DATE OF DEATH MONTH DAY YEAR November 14, 1994		3. TIME OF DEATH M M	
4. SOCIAL SECURITY NUMBER 215-14-7079		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 10, 1922	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) St. Agnes Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH Baltimore City				10a. STATE Maryland		10b. COUNTY Howard County	
10c. CITY, TOWN OR LOCATION Ellicott City				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 3332 N. Chatham Road Apt. #8	
10f. ZIP CODE 21042				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Janitor		16b. KIND OF BUSINESS/INDUSTRY Janitorial	
17. FATHER'S NAME (First, Middle, Last) Jiles Griffin				18. MOTHER'S NAME (First, Middle, Maiden Surname) Della Fender			
19a. INFORMANT'S NAME (Type/Print) Mrs. Louise Lewis				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3332 N. Chatham Road Apt. 8 Ellicott City, MD 21042			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Garrison Forest Cemetery 11/18/94		20c. LOCATION — City or Town, State Owings Mills, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Brian L. Haight				22. NAME AND ADDRESS OF FACILITY HAIGHT FUNERAL HOME (P.O. Box 195) Sykesville, MD 21784 (410)-795-1400			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Coronary Artery Disease Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseases or injury that initiated events resulting in death) LAST a. Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF): b. Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Stephen J. Panchot M.D.				29c. LICENSE NUMBER D23580		29d. DATE SIGNED (Month, Day, Year) 11/14/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) STEPHEN J. PANCHOT MD 349 WILKENS AVE BALTIMORE MD 21229							
31. DATE FILED (Month, Day, Year) NOV 15 1994				32. REGISTRAR'S SIGNATURE John A. ...			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33739

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ELOISE HOLMES				2. DATE OF DEATH MONTH 11 DAY 9 YEAR 94		3. TIME OF DEATH 12:18hr	
4. SOCIAL SECURITY NUMBER 247-46-7439		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 70 YRS.	IF UNDER 1 YEAR MONTHS _____ DAYS _____	IF UNDER 24 HRS. HOURS _____ MIN. _____	7. DATE OF BIRTH (Month, Day, Year) May 23, 1924	
8. BIRTHPLACE (State or Foreign Country) South Carolina				9a. FACILITY NAME (If not institution, give street and number) Harbor Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH				10a. STATE Maryland			
10b. COUNTY				10c. CITY, TOWN OR LOCATION Baltimore			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 2431 Terra Firma Road			
10f. ZIP CODE 21225				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) _____				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) House Wife		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) Joe Sam Frazier				18. MOTHER'S NAME (First, Middle, Maiden Surname) Irene Capers			
19a. INFORMANT'S NAME (Type/Print) Joel Holmes				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 113 S. Tremont Rd. Baltimore, Maryland 21229			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Garrison Forest Cem. 11/15		20c. LOCATION — City or Town, State Owings Mills Maryland		21. SIGNATURE OF FUNERAL SERVICE LICENSEE Kevin Parker	
22. NAME AND ADDRESS OF FACILITY Nutter Funeral Home Inc. 2501 Gwyn Falls PKY. Baltimore, Maryland 21216		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → INTRACEREBRAL BLEED a. DUE TO (OR AS A CONSEQUENCE OF): b. HYPERTENSION DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO						DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER P. Sharma HOUSE STAFF				29c. LICENSE NUMBER D-45249		29d. DATE SIGNED (Month, Day, Year) 11/9/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) P. Sharma HARBOR HOSPITAL CENTER							
31. DATE FILED (Month, Day, Year) NOV 16 1994		32. REGISTRAR'S SIGNATURE John Anderson					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

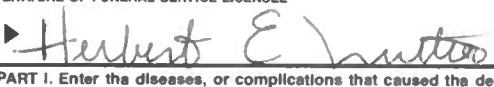
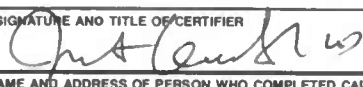
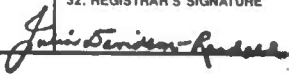
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33740

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Herbert N. Hall				2. DATE OF DEATH MONTH DAY YEAR Oct 22, 1994		3. TIME OF DEATH 11:00 a M	
4. SOCIAL SECURITY NUMBER 214-18-0409		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 71 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov 9 1922	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) 740 Poplar Grove Street Apt 12T		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH				10a. STATE Maryland		10b. COUNTY Baltimore	
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 740 Poplar Grove Street Apt 12T	
10f. ZIP CODE 21216				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) High School College (1-4 or 5+) Maintenance Man				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Maintenance Man		16b. KIND OF BUSINESS/INDUSTRY Goetze Meat Packing Company	
17. FATHER'S NAME (First, Middle, Last) Joseph Hall				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ada Hawkins			
19a. INFORMANT'S NAME (Type/Print) Lottie P. Hall				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3710 Calloway Avenue Baltimore, MD 21215			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Western Star Cemetery 10/28		20c. LOCATION — City or Town, State Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, Inc 2501 Gwynns Falls Parkway Baltimore, Maryland 21216			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. ASCVD DUE TO (OR AS A CONSEQUENCE OF): b. Diabetes DUE TO (OR AS A CONSEQUENCE OF): c. Hypertension DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death years years years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) Nov 16 1994	
28b. TIME OF INJURY M				28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D-12990		29d. DATE SIGNED (Month, Day, Year) 10/25/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) James Quinlan, MD 7801 York Rd. Towson, MD 21204							
31. DATE FILED (Month, Day, Year) NOV 16 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33741

Item#19a Film# G-717 Per F.H. 11/17/94 R.M.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Beenead Hilton				2. DATE OF DEATH MONTH 11 DAY 10 YEAR 94		3. TIME OF DEATH 1045P M	
4. SOCIAL SECURITY NUMBER 218 16 1261		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 71 YRS.		7. DATE OF BIRTH (Month, Day, Year) JUN. 11, 1923	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) BALTIMORE VETERANS HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY	
9c. COUNTY OF DEATH n/a				10a. STATE MARYLAND		10b. COUNTY n/a	
10c. CITY, TOWN OR LOCATION BALTIMORE				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 1000 ASHLAND COURT	
10f. ZIP CODE 21202				10g. CITIZEN OF WHAT COUNTRY? UNITED STATES		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 TH College (1-4 or 5+) -				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LABORER		16b. KIND OF BUSINESS/INDUSTRY CONSTRUCTION	
17. FATHER'S NAME (First, Middle, Last) GEORGE HILTON				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY SHEAR			
19a. INFORMANT'S NAME (Type/Print) BERNARD H. HILTON				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1108 N. BOND STREET, BALTIMORE, MD 21214			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GARRISON FOREST VA CEMETERY 11-180WINGS MILLS, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY WM.C. MARCH FH.-1101 E. NORTH AE.			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Fungemia Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. myelodysplasia b. Chronic Renal Insufficiency c. gout d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Suzanne C. Murphy, MD	
29c. LICENSE NUMBER				29d. DATE SIGNED (Month, Day, Year) 11-10-94		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Suzanne C. Murphy MD	
31. DATE FILED (Month, Day, Year) NOV 16 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33742

Item 7, g-717, 11-16-94, per F.H., dr

1 -
FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) DORA L. HAUGHTON				2. DATE OF DEATH 11 MONTH 09 DAY 94 YEAR		3. TIME OF DEATH 4:00 PM	
4. SOCIAL SECURITY NUMBER 220-12-9539		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 82 YRS.		7. DATE OF BIRTH NOV. 21, 1911	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL ASSOCIATION		9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE	
9c. COUNTY OF DEATH A.A. COUNTY				10a. STATE MARYLAND			
10b. COUNTY PASADENA				10c. CITY, TOWN OR LOCATION PASADENA			
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 63 MAGOTHY BEACH ROAD			
10f. ZIP CODE 21122				10g. CITIZEN OF WHAT COUNTRY? USA.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th GRADE College (1-4 or 5+) 12th GRADE		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) NURSE		16b. KIND OF BUSINESS/INDUSTRY ARMY HOSPITAL			
17. FATHER'S NAME (First, Middle, Last) WILLIAM A. JACKSON				18. MOTHER'S NAME (First, Middle, Maiden Surname) BERTIE HOWARD			
19a. INFORMANT'S NAME (Type/Print) LILLIAN SCURRY				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 63 MAGOTHY BEACH ROAD, PASADENA, MARYLAND 21122			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BALTIMORE NAT'L CEMETERY 11/15/94		20c. LOCATION — City or Town, State WOODLAWN, MARYLAND		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 	
22. NAME AND ADDRESS OF FACILITY JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTIMORE, MD. 21223		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Gram Negative Septicemia Due to (or as a consequence of): b. Multiple Myeloma Due to (or as a consequence of): c. Chronic Renal failure Due to (or as a consequence of): d. Multiple Debris Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Brain Syndrome.					
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Nomicide 7 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER D14136		29d. DATE SIGNED (Month, Day, Year) 11/10/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. DALJIT S. SAWHNEY, M.D./1600 CRAIN HIGHWAY, SW, #201/GLEN BURNIE, MD 21061							
31. DATE FILED NOV 16 1994		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94-6497-510

DWG

Item 18, g-717, 11-16-94, per F.H., dr

94 33743

1 -
FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) DERRICK VON HUGHES				2. DATE OF DEATH MONTH NOV. DAY 09 YEAR 94		3. TIME OF DEATH 5:05P M	
4. SOCIAL SECURITY NUMBER 215-82-2943		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 25 YRS.		7. DATE OF BIRTH (Month, Day, Year) JAN. 19, 1969	
9a. FACILITY NAME (If not institution, give street and number) 201 REEBIRD PARK				9b. CITY, TOWN OR LOCATION OF DEATH BALTO. CITY		9c. COUNTY OF DEATH n/a	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY n/a		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 3011 SOUTHLAND AVENUE 1st floor				10f. ZIP CODE 21225		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 TH College (1-4 or 5+) -		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LABORER		16b. KIND OF BUSINESS/INDUSTRY STACEY'S BUFFET RESTAURANT			
17. FATHER'S NAME (First, Middle, Last) JONATHAN HUGHES JR.				18. MOTHER'S NAME (First, Middle, Maiden Surname) STEPHANIE BUTLER Butler			
19a. INFORMANT'S NAME (Type/Print) STEPHANIE BUTLER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3009 LA RUE SQUARE, BALTIMORE, MD 21225			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT. ZION CEMETERY 11-16		20c. LOCATION — City or Town, State LANSLOWNE, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Karen M. Kogen				22. NAME AND ADDRESS OF FACILITY WM. C. MARCH Ph.-1101 E. NORTH AVENUE			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple Gunshot Wounds DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) PARK AREA					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 11-9-94		28b. TIME OF INJURY 1700P M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED Subject shot		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) park		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 201 Reebird Park Baltimore City, Md	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Dennis J. Chute MD				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) NOV. 10/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) NOV 16 1994				32. REGISTRAR'S SIGNATURE John B. ...			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. The funeral director, page 5 should be detached for use in the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33744

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) James Howard Hess				2. DATE OF DEATH MONTH Nov DAY 14 YEAR 94		3. TIME OF DEATH 0542 M	
4. SOCIAL SECURITY NUMBER 218-03-1267		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 81 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan. 26, 1913	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Keswick Home		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City	
9c. COUNTY OF DEATH N/A				10a. STATE Maryland			
10b. COUNTY N/A				10c. CITY, TOWN OR LOCATION Baltimore City			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 111 Hamlet Hill Road Apt. 705			
10f. ZIP CODE 21210				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Architectural Consultant		17. KIND OF BUSINESS/INDUSTRY Paint Company			
17. FATHER'S NAME (First, Middle, Last) Harry Hess				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Hornsby			
19a. INFORMANT'S NAME (Type/Print) Mary Elizabeth Hess				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 Hamlet Hill Rd. Apt. 705 Balto. MD 21210			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Rose Hill Memorial Park		DATE 11-17		20c. LOCATION — City or Town, State Rocky Hill, Connecticut	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE George Fenam				22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. END STAGE Renal Disease DUE TO (OR AS A CONSEQUENCE OF):				Approximate Interval Between Onset and Death 4 yrs	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. Hypertension DUE TO (OR AS A CONSEQUENCE OF):				40 yrs	
		c. _____ DUE TO (OR AS A CONSEQUENCE OF):					
		d. _____ DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary artery Disease & CABG							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFIED PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]				29c. LICENSE NUMBER D22334		29d. DATE SIGNED (Month, Day, Year) 14 NOV 94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOSEPH M. D. 700 W 40th STREET Baltimore 2124							
31. DATE FILED (Month, Day, Year) NOV 16 1994				32. REGISTRAR'S SIGNATURE [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33745

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) FRANK H. JAMES, JR.				2. DATE OF DEATH MONTH DAY YEAR Nov. 15, 1994		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 214-01-5286		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 80 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec. 25, 1913	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Carroll County General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Westminster	
9c. COUNTY OF DEATH Carroll County				10a. STATE Maryland		10b. COUNTY Baltimore	
10c. CITY, TOWN OR LOCATION Randallstown				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 9071 Meadow Heights Road	
10f. ZIP CODE 21133				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Warehouse Manager		16b. KIND OF BUSINESS/INDUSTRY Tri-State Electrical Supply	
17. FATHER'S NAME (First, Middle, Last) Frank H. James, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Madlana Stewart			
19a. INFORMANT'S NAME (Type/Print) Mrs. Dorothy James				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9071 Meadow Heights Rd. Randallstown, MD 21133			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Woodlawn Cemetery		20c. LOCATION — City or Town, State 11/19 Woodlawn, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE John K. Ayres				22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, MD 21133			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF): b. Chronic obstructive Pulmon DUE TO (OR AS A CONSEQUENCE OF): c. disease end stage DUE TO (OR AS A CONSEQUENCE OF): d. Congestive Heart Failure Approximate Interval Between Onset and Death 20 min 20 years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER H.D.				29c. LICENSE NUMBER D38915		29d. DATE SIGNED (Month, Day, Year) 11/15/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FREIJI 542 WASH RD Westminster MD							
31. DATE FILED (Month, Day, Year) NOV 16 1994				32. REGISTRAR'S SIGNATURE John K. Ayres			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33746

Item 10b, g-717, 11-16-94, per F.H., dr

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CLARENCE WILLIAM JOHNSON JR.				2. DATE OF DEATH NOV. 14, 1994 YEAR		3. TIME OF DEATH 10:55 A M	
4. SOCIAL SECURITY NUMBER 219-18-7436		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 69 YRS.		7. DATE OF BIRTH (Month, Day, Year) Apr. 27, 1925	
9a. FACILITY NAME (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH Towson		9c. COUNTY OF DEATH BALTIMORE			
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Timonium Baltimore		10c. CITY, TOWN OR LOCATION Timonium		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 215 Coldbrook Road				10f. ZIP CODE 21093		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Korea		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Mechanical Engineer		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) Clarence W. Johnson, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) M Hilda Sawyer			
19a. INFORMANT'S NAME (Type/Print) Mrs. Mary E. Johnson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 215 Coldbrook Road Timonium, Maryland 21093			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Cem. 11/17/94		20c. LOCATION — City or Town, State Baltimore Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael J. Duck</i>				22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Rd			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>CARDIAC ARREST</u> Due to (or as a consequence of): b. <u>ARTERIO SCLEROTIC C.V. DISEASE 10 YRS</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate interval between Onset and Death: <u>INSTANT</u>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>HEMIPARESIS 2° TO C.V.A.</u>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Henri T. Voorstad, M.D.</i>		29c. LICENSE NUMBER <i>D11064</i>		29d. DATE SIGNED (Month, Day, Year) <i>11-15-1994</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. HENRI T. VOORSTAD 7600 OSLER DRIVE TOWSON, MD.							
31. DATE FILED (Month, Day, Year) NOV 16 1994		32. REGISTRAR'S SIGNATURE <i>Julia Burden</i>					

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached to the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

94 33747

ITEMS: 1.7.9b,19a, PER F.H. FILM G-717 11/16/94 t.t

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) DERRICK EUGENE JONES				2. DATE OF DEATH NOVEMBER 11, 1994		3. TIME OF DEATH n/a	
4. SOCIAL SECURITY NUMBER 214-12-0755		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 19 YRS.		7. DATE OF BIRTH (Month, Day, Year) NOV 24, 1975	
9a. FACILITY NAME (If not institution, give street and number) 5718 FENWICK AVENUE				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH n/a	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY n/a		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 5718 FENWICK AVENUE				10f. ZIP CODE 21239		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 TH College (1-4 or 5+) -				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) STUDENT		16b. KIND OF BUSINESS/INDUSTRY n/a	
17. FATHER'S NAME (First, Middle, Last) NORRIS E. JONES				18. MOTHER'S NAME (First, Middle, Maiden Surname) CAROLYN V. BOOKER			
19a. INFORMANT'S NAME (Type/Print) CAROLYN V. JONES				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5718 FENWICK AVENUE, BALTIMORE, MD 21239			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BALTIMORE CEMETERY 11-16		20c. LOCATION — City or Town, State BALTIMORE, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Karen M. Koger				22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH AVENUE			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → osteosarcoma DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate interval Between Onset and Death 3 yr.	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER M.D.				29c. LICENSE NUMBER D45625		29d. DATE SIGNED (Month, Day, Year) 11/11/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) WING-HANG LEUNG M.D. CMSC 800 JOHNS HOPKINS HOSPITAL							
31. DATE FILED (Month, Day, Year) NOV 16 1994				32. REGISTRAR'S SIGNATURE Julia Anderson-Rodell			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33748

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) EDNA KIDWELL		2. DATE OF DEATH MONTH DAY YEAR NOV 10, 1994		3. TIME OF DEATH HOURS MINUTES 7:55 A	
4. SOCIAL SECURITY NUMBER 579-40-1516	5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 64 YRS.	7. DATE OF BIRTH (Month, Day, Year) DEC. 8, 1929	8. BIRTHPLACE (State or Foreign Country) VIRGINIA	
9a. FACILITY NAME (If not institution, give street and number) LAUREL REGIONAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH LAUREL		9c. COUNTY OF DEATH PRINCE GEORGE	
10a. STATE MARYLAND		10b. COUNTY PRINCE GEORGE		10c. CITY, TOWN OR LOCATION LAUREL	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 8903 MERRILL LANE #202		10f. ZIP CODE 20708	
10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 0	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) FACTORY WORKER		16b. KIND OF BUSINESS/INDUSTRY ELECTRONICS			
17. FATHER'S NAME (First, Middle, Last) OTHO T. JARRALL		18. MOTHER'S NAME (First, Middle, Maiden Surname) HARRIET COLLINS			
19a. INFORMANT'S NAME (Type/Print) KATHLEEN KIDWELL		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8903 MERRILL LANE #202, LAUREL, MARYLAND 20708			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BALTIMORE-WASHINGTON CREM 11/14		20c. LOCATION — City or Town, State LAUREL, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>		22. NAME AND ADDRESS OF FACILITY FLECK FUNERAL HOME, INC 7601 SANDY SPRING ROAD, LAUREL, MD 20707			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>arteriosclerotic cardiovascular disease</i> DUE TO (OR AS A CONSEQUENCE OF):			
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. DUE TO (OR AS A CONSEQUENCE OF):			
		c. DUE TO (OR AS A CONSEQUENCE OF):			
		d. DUE TO (OR AS A CONSEQUENCE OF):			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetes mellitus</i>					
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY HOURS MINUTES 11 00	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> M.D.		29c. LICENSE NUMBER 012879		29d. DATE SIGNED (Month, Day, Year) NOV. 11, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DEBORAH VALLEY M.D. 10701 TRAFLET DR., LAUREL, MD 20772					
31. DATE FILED (Month, Day, Year) NOV 16 1994		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33749

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Robert John Logue Sr.				2. DATE OF DEATH MONTH Nov. DAY 11 YEAR 1994		3. TIME OF DEATH 10:28am M	
4. SOCIAL SECURITY NUMBER 214-26-7245		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 65 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 7, 1929	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Rossville	
9c. COUNTY OF DEATH Baltimore				10a. STATE Md.		10b. COUNTY Baltimore	
10c. CITY, TOWN OR LOCATION Middle River				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 16 Hammock Trail	
10f. ZIP CODE 21220				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: White				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4 or 5+) College			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Electric Tech				16b. KIND OF BUSINESS/INDUSTRY Electronics			
17. FATHER'S NAME (First, Middle, Last) Andrew Logue				18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Cummins			
19a. INFORMANT'S NAME (Type/Print) Charlotte Logue				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16 Hammock Trail Baltimore Md. 21220			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Holly Hill Cemetery 11/14/94 Baltimore Md.			
20c. LOCATION — City or Town, State				21. SIGNATURE OF FUNERAL SERVICE LICENSEE R. Terry Connelly			
22. NAME AND ADDRESS OF FACILITY Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. INTRAPULMONARY HEMORRHAGE DUE TO (OR AS A CONSEQUENCE OF): b. VASCULITIS DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST			
24. Approximate Interval Between Onset and Death 5 MIN				25. Approximate Interval Between Onset and Death 1 MTH			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) Nov. 11, 1994			
28b. TIME OF INJURY M				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER R. Terry Connelly M.D.				29c. LICENSE NUMBER AF 232-8412-1757			
29d. DATE SIGNED (Month, Day, Year) 11/15/94				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ROBERT DE LA TORRE, M.D. 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237			
31. DATE FILED (Month, Day, Year) NOV 16 1994				32. REGISTRAR'S SIGNATURE John Sanders-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,


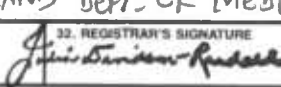
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33750

Item#2 Per F.H. Film# G-717 11/18/94 R.M.
 FOR
 STATE
 REGISTRAR
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
 REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) WAYNE A LANSEY				2. DATE OF DEATH MONTH 11 DAY 11 YEAR 1994		3. TIME OF DEATH 7:44 P M	
4. SOCIAL SECURITY NUMBER 2547580908		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 44 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10/10/50	
8. BIRTHPLACE (State or Foreign Country) Balto. Md		9a. FACILITY NAME (If not institution, give street and number) UNIV. OF MARYLAND HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH	
10a. STATE Maryland				10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 1545 Stonewood Rd.		10f. ZIP CODE 21239	
10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1-2-69 - 6-1-72		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: Black		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) Labor		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Chauffer		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) William A. Lansey Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Patricia M. Jones			
19a. INFORMANT'S NAME (Type/Print) Agatha M. Lansey				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1545 Stonewood Rd. Balto. Md 21239			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Garrison Forest Vet. 11-18		20c. LOCATION — City or Town, State Owings Mills, Md		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 	
22. NAME AND ADDRESS OF FACILITY William C. Brown Comm. FH, 1206 W. North Ave Balto. Md #17		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → SEPSIS Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. LARGE CELL LYMPHOMA						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER Kenneth Lin MD		29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 11/11/94		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) KENNETH LIN, MD UNIV. OF MARYLAND DEPT. OF MEDICINE, 22 S. GREENE ST. BALTIMORE MD 2120	
31. DATE FILED (Month, Day, Year) NOV 16 1994		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

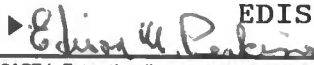


TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33751

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARIE KATHERINE LUCAS				2. DATE OF DEATH MONTH DAY YEAR NOV. 6, 1994		3. TIME OF DEATH 4:30 A M	
4. SOCIAL SECURITY NUMBER 212-03-2721		5. SEX 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 87 YRS.		7. DATE OF BIRTH (Month, Day, Year) 4/29/ 1907	
9a. FACILITY NAME (If not institution, give street and number) MERIDIAN - MULTI MED. CENTER				9b. CITY, TOWN OR LOCATION OF DEATH TOWSON		9c. COUNTY OF DEATH BALTIMORE	
RESIDENCE OF DECEDENT							
10a. STATE MD.		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION PHOENIX		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 13600 JARRETTSVILLE PIKE				10f. ZIP CODE 21131		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER		16b. KIND OF BUSINESS/INDUSTRY OWN HOME			
17. FATHER'S NAME (First, Middle, Last) ALFRED FURTHMAIER				16. MOTHER'S NAME (First, Middle, Maiden Surname) LUCY FELSCH			
19a. INFORMANT'S NAME (Type/Print) GEORGE N. LUCAS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21131 13600 JARRETTSVILLE PIKE, PHOENIX, MD.			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GREEN MT. CREMATORY 11/7		DATE 11/7		20c. LOCATION — City or Town, State BALTIMORE, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  EDISON M. PERKINS D 00083				22. NAME AND ADDRESS OF FACILITY BRADLEY-ASHTON FUNERAL HOME INC. 2134 WILLOW SPRING RD. DUNDALK, MD.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → s. CEREBRALVASCULAR ACCIDENT DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death 1 YR.	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PARKINSONS						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D29364		29d. DATE SIGNED (Month, Day, Year) NOV. 15, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JEFFREY D. GABER M.D. 2360 WEST JOPPA ROAD, LUTHERVILLE, MD. 21093							
31. DATE FILED (Month, Day, Year) NOV 16 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33752

Items 1 & 4, g-717, 11-16-94, per F.H., dr

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LAGUEUX ROLAND Roland Lagueux				2. DATE OF DEATH MONTH 11 DAY 14 YEAR 1994		3. TIME OF DEATH 9:45 A.M.	
4. SOCIAL SECURITY 007-26-2129 999-94-3790		5. AGE (In yrs. last birthday) 61 YRS.		6. DATE OF BIRTH (Month, Day, Year) July 8, 1933		6. BIRTHPLACE (State or Foreign Country) ME	
9a. FACILITY NAME (If not institution, give street and number) GOOD SAMARITAN HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE Md		10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 5640 Belair Road				10f. ZIP CODE 21206		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Disabled Veteran		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) Albany Lagueux, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Marie Rose Henaire			
19a. INFORMANT'S NAME (Type/Print) Thaxter Lagueux				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5640 Belair Road, Baltimore, Md 21206			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Goodwin's Mills Cemetery 11/19		20c. LOCATION — City or Town, State Goodwin Mills, Maine			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Philip Stach M00550				22. NAME AND ADDRESS OF FACILITY STERLING ASHTON FUNERAL HOME, INC. 736 EDMONDSON AVE., BALTIMORE, MD. 21228			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → CARDIOGENIC SHOCK Approximate interval Between Onset and Death 2 hours							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST MYOCARDIAL INFARCTION 42 HOURS							
c. CORONARY ARTERY DISEASE YEARS							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER M.D.				29c. LICENSE NUMBER P 7619		29d. DATE SIGNED (Month, Day, Year) 11.14.94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) NOV 16 1994				32. REGISTRAR'S SIGNATURE [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or the funeral director, page 5 should be detached and filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33753

Items 6 & 7, g-717, 11-16-94, per F.H., dr

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) IRVIN FRANCIS LANE				2. DATE OF DEATH MONTH NOV DAY 12 YEAR 94		3. TIME OF DEATH 10 P M	
4. SOCIAL SECURITY NUMBER 214-20-4555		5. SEX 1 M 2 F		6. AGE (In yrs. last birthday) 68 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 8, 1926	
9a. FACILITY NAME (If not institution, give street and number) Stella Maris Hospice				9b. CITY, TOWN OR LOCATION OF DEATH		9c. COUNTY OF DEATH Baltimore	
10a. STATE Md				10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore	
10d. INSIDE CITY LIMITS? 1 X YES 2 NO							
10e. STREET AND NUMBER 402 North Linwood Avenue				10f. ZIP CODE 21224		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 Never Married 2 X Married 3 Widowed 4 Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 X NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Plant Worker		16b. KIND OF BUSINESS/INDUSTRY Laundry					
17. FATHER'S NAME (First, Middle, Last) A. Lane				18. MOTHER'S NAME (First, Middle, Maiden Surname) Cora Ekels			
19a. INFORMANT'S NAME (Type/Print) Carmella Lane				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 402 North Linwood Avenue, Balto, Md. 21224			
20a. METHOD OF DISPOSITION 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Greenmount Crematory 11/15		20c. LOCATION — City or Town, State Baltimore, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> MOO550				22. NAME AND ADDRESS OF FACILITY Moran-Ashton Funeral Home 3000 E. Baltimore Street, Balto, Md. 21224			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → LIVER METASTASES DUE TO (OR AS A CONSEQUENCE OF): COLON CANCER DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death months months
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 X NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 X NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 X Other (Specify) Hospice					
27. MANNER OF DEATH 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 YES 2 NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Kendall R Faulkner</i>				29c. LICENSE NUMBER D75643		29d. DATE SIGNED (Month, Day, Year) 11/14/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. KENDALL FAULKNER, 2300 DULANEY VALLEY RD., TOWSON, MD 21204							
31. DATE FILED (Month, Day, Year) NOV 16 1994				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21213-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the death certificate permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33754

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Parthenia Lewis				2. DATE OF DEATH MONTH 11 DAY 15 YEAR 94		3. TIME OF DEATH 3:30 A.M.	
4. SOCIAL SECURITY NUMBER 246-05-8707		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (in yrs. last birthday) 77 YRS.	7. DATE OF BIRTH (Month, Day, Year) 9/24/17		8. BIRTHPLACE (State or Foreign Country) N.C.	
9a. FACILITY NAME (If not institution, give street and number) 2412 W. Cold Spring La.				9b. CITY, TOWN OR LOCATION OF DEATH Balto.		9c. COUNTY OF DEATH	
10a. STATE Balto Md.				10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 2412 W. Cold Spring La.		10f. ZIP CODE 21215	
10g. CITIZEN OF WHAT COUNTRY? USA				11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: Black			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Security		16b. KIND OF BUSINESS/INDUSTRY Walters Art Gallery	
17. FATHER'S NAME (First, Middle, Last) William Boyd				18. MOTHER'S NAME (First, Middle, Maiden Surname) Martha Gorrell			
19a. INFORMANT'S NAME (Type/Print) Robert C. Lewis				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2412 W. Cold Spring La. Balto., Md.			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) King Mem. Park 11/19		20c. LOCATION — City or Town, State Balto., Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James A. Morton</i>				22. NAME AND ADDRESS OF FACILITY James A. Morton & Sons 1701 Laurens St. Balto., Md. 21217			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic Breast Carcinoma Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Marshall A. Levine</i>				29c. LICENSE NUMBER D17873		29d. DATE SIGNED (Month, Day, Year) 11/16/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Marshall A. Levine, MD. 4000 Old Court Rd, Pikesville, MD 2128							
31. DATE FILED (Month, Day, Year) NOV 16 1994				32. REGISTRAR'S SIGNATURE <i>John Benner-Rubels</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

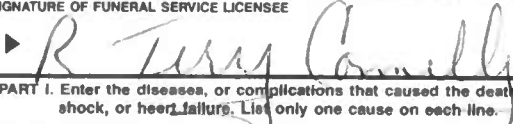
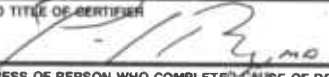

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33755

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) William (Billie) Bryant Morris				2. DATE OF DEATH MONTH DAY YEAR Nov. 12. 1994		3. TIME OF DEATH 3:16am M	
4. SOCIAL SECURITY NUMBER 244-07-7318		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan. 22, 1916	
9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Rossville		9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT							
10a. STATE Md.		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Middle River		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 9 Eva Court				10f. ZIP CODE 21220		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6th College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Painter		16b. KIND OF BUSINESS/INDUSTRY Construction	
17. FATHER'S NAME (First, Middle, Last) Mac Morris				18. MOTHER'S NAME (First, Middle, Maiden Surname) Edith Toler			
19a. INFORMANT'S NAME (Type/Print) Richard Morris				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Eva Court Baltimore Md. 21220			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cedarwood Cemetery		20c. LOCATION — City or Town, State Roanoke Rapids NC		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → TONSILLAR CANCER DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER 1516		29d. DATE SIGNED (Month, Day, Year) 11/15/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) NOV 16 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33756

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Joshua J. Maynor</u>				2. DATE OF DEATH MONTH <u>11</u> DAY <u>19</u> YEAR <u>94</u>		3. TIME OF DEATH <u>4:45 P.M.</u>	
4. SOCIAL SECURITY NUMBER <u>212-32-1354</u>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. MONTHS DAYS		7. DATE OF BIRTH (Month, Day, Year) <u>12-23-25</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>ST. ELIZABETHS N/H</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>BALTIMORE CITY</u>		9c. COUNTY OF DEATH	
10a. STATE <u>MD.</u>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <u>BALTIMORE CITY</u>		10d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10e. STREET AND NUMBER <u>3320 BENSON AVENUE</u>				10f. ZIP CODE <u>21227</u>		10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>BLACK</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>unknown</u> College (1-4 or 5+) <u>unknown</u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>unknown</u>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <u>WALTER MAYNOR</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>CORNELIA LEWIS</u>			
19a. INFORMANT'S NAME (Type/Print) <u>JOHN M. MAYNOR-BROTHER</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>459 SCHWARTZ AVENUE BALTO. MD. 21212</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DATE		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Irvin Carroll</u>				22. NAME AND ADDRESS OF FACILITY <u>IRVIN CARROLL F/H 1712 W. NORTH AVE.</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Possible Sepsis</u> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <u>Decubitus ulceration</u> PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>mental retardation</u>							Approximate interval Between Onset and Death
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Edmund P. Tkaczuk MD</u>				29c. LICENSE NUMBER <u>D34951</u>		29d. DATE SIGNED (Month, Day, Year) <u>11-15-94</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>EDMUND P. TKACZUK MD 405 Frederick Rd. Dr. John Catmanville MD 21224</u>							
31. DATE FILED (Month, Day, Year) <u>NOV 16 1994</u>		32. REGISTRAR'S SIGNATURE <u>John Benbow-Randall</u>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33757

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) EMMA B. McCARDELL				2. DATE OF DEATH MONTH DAY YEAR 11-13-1994		3. TIME OF DEATH 6:30^P	
4. SOCIAL SECURITY NUMBER 217-03-9957		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 86 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb, 13, 1908	
9a. FACILITY NAME (If not institution, give street and number) EAST POINT MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH Baltimore	
10a. STATE Md		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION 21219		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 3001 Delmar Avenue				10f. ZIP CODE 21219		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 11		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Clerk		16b. KIND OF BUSINESS/INDUSTRY Sales			
17. FATHER'S NAME (First, Middle, Last) Reginald Edwards				18. MOTHER'S NAME (First, Middle, Maiden Surname) Annie			
19a. INFORMANT'S NAME (Type/Print) Mr. Emmett B. McCardell				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3001 Delmar Avenue, Baltimore, Md. 21219			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Greenmount United Methodist		20c. LOCATION — City or Town, State 11/16 Hampstead, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Phillips Stacks m00550</i>				22. NAME AND ADDRESS OF FACILITY Bradley-Ashton Funeral Home 2134 Willow Spring Road, Dundalk, Md. 21222			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Ca of rectum</i> DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Parkinson's disease</i>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>B.R. Matos M.D. - Physician</i>		29c. LICENSE NUMBER D-14618		29d. DATE SIGNED (Month, Day, Year) 11/14/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) B.R. MATOS, M.D. 21 Cranbrook Rd Cockeysville Md. 21030							
31. DATE FILED (Month, Day, Year) NOV 16 1994		32. REGISTRAR'S SIGNATURE <i>John S. ...</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33758

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>George McCoy</u>				2. DATE OF DEATH MONTH <u>11</u> DAY <u>12</u> YEAR <u>94</u>		3. TIME OF DEATH <u>9 30 A M</u>	
4. SOCIAL SECURITY NUMBER <u>218-10-4666</u>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>87</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>4/27/07</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>Greenery Extended Care Ct.</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Balto.</u>		9c. COUNTY OF DEATH	
10a. STATE <u>Md.</u>				10b. COUNTY <u>Baltimore</u>		10c. CITY, TOWN OR LOCATION <u>Baltimore</u>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <u>2727 Rosedale St.</u>			
10f. ZIP CODE <u>21216</u>				10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>Black</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>Collega (1-4 or 5+)</u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Laborer</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Construction</u>			
17. FATHER'S NAME (First, Middle, Last) <u>Frank McCoy</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Annie K. White</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Margaret Mc Coy</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>2727 Rosedale St. Balto., Md. 21216</u>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Md. National Mem Pk.</u>		20c. LOCATION — City or Town, State <u>11/17 Laurel, Md.</u>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>James A. Morton</u>				22. NAME AND ADDRESS OF FACILITY <u>James A. Morton & Sons</u> <u>1701 Laurens St., Balto., Md. 21217</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Congestive Heart Failure</u> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate interval Between Onset and Death <u>2 weeks</u>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Intermittent Illness</u> <u>Stroke</u> <u>Renal Insufficiency</u>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Michael M.D.</u>				29c. LICENSE NUMBER <u>D38675</u>		29d. DATE SIGNED (Month, Day, Year) <u>11/14/94</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>JOEL MESHLAM 1147 SHANOVER ST BALT MD 21230</u>							
31. DATE FILED (Month, Day, Year) <u>NOV 16 1994</u>				32. REGISTRAR'S SIGNATURE <u>John S. Russell</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed without delay after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33759

Item 19b, g-717, 11-16-94, per F.H., dr

1 -
FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Jency McClinton				2. DATE OF DEATH MONTH DAY YEAR 11 14 94		3. TIME OF DEATH 8 10 P M	
4. SOCIAL SECURITY NUMBER 218-26-1362		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 80 YRS.	7. DATE OF BIRTH (Month, Day, Year) JUN. 1, 1914		8. BIRTHPLACE (State or Foreign Country) N. CAROLINA	
9a. FACILITY NAME (If not institution, give street and number) St Agnes Hospital				9b. CITY, TOWN OR LOCATION OF DEATH n/a		9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY n/a		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 2113 HOMEWOOD AVENUE				10f. ZIP CODE 21218		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) n/a College (1-4 or 5+) -				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DOMESTIC ENGINEER		16b. KIND OF BUSINESS/INDUSTRY (self employed) DAYCARE/SHELTER	
17. FATHER'S NAME (First, Middle, Last) ROBERT HOLLAND				18. MOTHER'S NAME (First, Middle, Maiden Surname) ALMA BALLOCK			
19a. INFORMANT'S NAME (Type/Print) ANITA M. WASHINGTON				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3167 HOLLY SPRING RD, AMISSVILLE, VA 22002			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT. CALVARY CEMETERY 11-17		20c. LOCATION — City or Town, State ANNE ARUNDEL, CO, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH AVENUE			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Status Epilepticus							
Due to (or as a consequence of):							
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
Due to (or as a consequence of): Cerebrovascular Accident							
Due to (or as a consequence of): Fulminant Hepatitis							
Due to (or as a consequence of):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D42826		29d. DATE SIGNED (Month, Day, Year) 11/14/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert Lampert St Agnes Hospital Baltimore Maryland							
31. DATE FILED (Month, Day, Year) 11/14/94				32. REGISTRAR'S SIGNATURE 			

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

94-6573-510

CIP

94 33760

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-718 12/5/94 t.t.

1 -
FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) DENISE THIRZA PARHAM				2. DATE OF DEATH MONTH DAY YEAR NOVEMBER 13, 1994		3. TIME OF DEATH 1:17 P M	
4. SOCIAL SECURITY NUMBER 212-76-2484		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 35 YRS.		7. DATE OF BIRTH (Month, Day, Year) JUNE 22, 1959	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) 414 SOUTHWAY		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE	
9c. COUNTY OF DEATH BALTIMORE				10a. STATE MARYLAND		10b. COUNTY BALTIMORE	
10c. CITY, TOWN OR LOCATION BALTIMORE CITY				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 414 SOUTHWAY	
10f. ZIP CODE 21218				10g. CITIZEN OF WHAT COUNTRY? USA.		11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 1 YEAR College (1-4 or 5+) CLERK				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CLERK		16b. KIND OF BUSINESS/INDUSTRY POST OFFICE	
17. FATHER'S NAME (First, Middle, Last) WILLIAM PARHAM				18. MOTHER'S NAME (First, Middle, Maiden Surname) EDNA ROLLINS			
19a. INFORMANT'S NAME (Type/Print) WILLIAM PARHAM				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2630 W. COLDSRING LANE, BALTIMORE, MD. 21215			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) METRO CREMATORY, INC. 11-15-94		20c. LOCATION — City or Town, State BALTIMORE, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTIMORE, MD. 21223			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. NARCOTIC INTOXICATION DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 11-13-94 FOUND		28b. TIME OF INJURY 12:55 P M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED UNKNOWN		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) HOME					
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 414 SOUTHWAY BALTIMORE, MD.		29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) NOVEMBER 14, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARIO F. GOBLE, JR. MD 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) NOV 16 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.


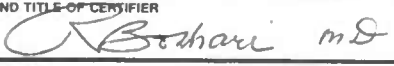
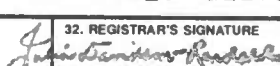
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33761

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Henry S. Potter				2. DATE OF DEATH MONTH DAY YEAR November 11, 94		3. TIME OF DEATH 3:57 P M	
4. SOCIAL SECURITY NUMBER 294-28-0029		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 61 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Jan. 4, 1933	
9a. FACILITY NAME (If not institution, give street and number) Greater Baltimore Medical Center				9b. CITY, TOWN OR LOCATION OF DEATH Towson		9c. COUNTY OF DEATH Baltimore County	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Baltimore County		10c. CITY, TOWN OR LOCATION -----		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 8 Meadow Road				10f. ZIP CODE 21212		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1958-59		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) P & H Auto Electric		16b. KIND OF BUSINESS/INDUSTRY Automobile Supply			
17. FATHER'S NAME (First, Middle, Last) Frederick Taylor Potter				18. MOTHER'S NAME (First, Middle, Maiden Surname) Marsha Stickney			
19a. INFORMANT'S NAME (Type/Print) Mrs. Sara H. Potter				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 Meadow Road Baltimore, Md. 21212			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Dulaney Valley Mem. Grds. 11/14/94		20c. LOCATION — City or Town, State Timonium, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home, Inc. 6500 York Road Balto. Md. 21212			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Malignant Melanoma							
b. DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nonicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  MD				29c. LICENSE NUMBER D-26594		29d. DATE SIGNED (Month, Day, Year) 11/11/1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Riaz Bokhari 7505 Osler Drive Towson, Md. 21204							
31. DATE FILED (Month, Day, Year) NOV 16 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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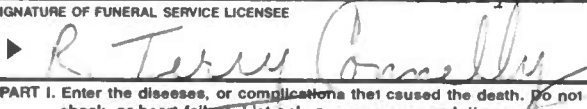

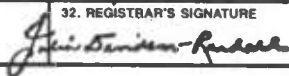
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also

94 33762

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) James Francis Robertson Sr.				2. DATE OF DEATH MONTH Nov. DAY 9 YEAR 1994		3. TIME OF DEATH 11:55pm	
4. SOCIAL SECURITY NUMBER 231-16-5464		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 30, 1922	
9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Rossville		9c. COUNTY OF DEATH Baltimore	
10a. STATE Md.		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Middle River		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 34 Longeron Drive				10f. ZIP CODE 21220		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Auto Worker		16b. KIND OF BUSINESS/INDUSTRY Auto Maker			
17. FATHER'S NAME (First, Middle, Last) Howard R. Robertson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Irene Craft			
19a. INFORMANT'S NAME (Type/Print) Teresa Robertson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2117 Coralhorn Road Baltimore Md. 21220			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Holly Hill Cemetery 11/12/94		20c. LOCATION — City or Town, State Baltimore Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY Connolly Funeral Home of Essex 300 Mace Ave Baltimore Md. 21221					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Bladder Ca Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D18487		29d. DATE SIGNED (Month, Day, Year) 11/15/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MYO THANT 9601 FRANKLIN SQUARE DR, BALTO, MD 21237							
31. DATE FILED (Month, Day, Year) NOV 16 1994		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33763

Item 1, g-717, 11-16-94, per F.H., dr

1 -
FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARJORIE EUGENIA RYLEE				2. DATE OF DEATH MONTH DAY YEAR NOV. 15, 1994		3. TIME OF DEATH 1:30 A M	
4. SOCIAL SECURITY NUMBER 214-74-2509		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 89 YRS.		7. DATE OF BIRTH (Month, Day, Year) SEPT. 9, 1905	
9a. FACILITY NAME (If not institution, give street and number) MANOR CARE - TOWSON				9b. CITY, TOWN OR LOCATION OF DEATH TOWSON		9c. COUNTY OF DEATH BALTIMORE	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION LUTHERVILLE		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 125 WARWICK DRIVE				10f. ZIP CODE 21093		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE		16b. KIND OF BUSINESS/INDUSTRY AT HOME	
17. FATHER'S NAME (First, Middle, Last) DANIEL WALDRIP				18. MOTHER'S NAME (First, Middle, Maiden Surname) KATHERINE COLEMAN			
19a. INFORMANT'S NAME (Type/Print) KATHERINE MEYER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7006 YORK ROAD BALTIMORE, MD. 21212			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HILLTOP SERVICE CORP. 11/16/94 TOWSON, MD.		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE JOHN E. DOLAN				22. NAME AND ADDRESS OF FACILITY RUCK TOWSON FUNERAL HOME INC. 1050 YORK ROAD TOWSON, MD. 21204			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Coronary Artery Disease</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Congestive Heart Failure</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Joseph Adams				29c. LICENSE NUMBER D32783		29d. DATE SIGNED (Month, Day, Year) 11/15/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. JOSEPH ADAMS 7401 Osler Drive Suite 206 Towson, md.							
31. DATE FILED (Month, Day, Year) NOV 16 1994				32. REGISTRAR'S SIGNATURE			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for filing with the funeral permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33764

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Jason M. Smith</i>				2. DATE OF DEATH MONTH <i>November</i> DAY <i>8</i> , YEAR <i>1994</i>				3. TIME OF DEATH <i>7:15 A.</i> M	
4. SOCIAL SECURITY NUMBER <i>N/A</i>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>November 8, 94</i>		8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Holy Cross Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Silver Spring</i>				9c. COUNTY OF DEATH <i>Montgomery</i>	
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Montgomery</i>		10c. CITY, TOWN OR LOCATION <i>Silver Spring</i>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>3225 Hewitt Avenue #103</i>				10f. ZIP CODE <i>20906</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>N/A</i> College (1-4 or 5+) <i>N/A</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>N/A</i>		16b. KIND OF BUSINESS/INDUSTRY <i>N/A</i>					
17. FATHER'S NAME (First, Middle, Last) <i>Walter C. Smith</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Christine Herron</i>					
19a. INFORMANT'S NAME (Type/Print) <i>Walter & Christine Smith</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3225 Hewitt Avenue #103, Silver Spring, MD 20906</i>					
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Baltimore Washington Crem 11/10</i>		20c. LOCATION — City or Town, State <i>Laurel, Maryland</i>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <i>Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, MD 20707</i>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Extreme immaturity</i> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <i>Extreme immaturity</i> b. c. d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								Approximate Interval Between Onset and Death <i>3 1/2 hr.</i>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <i>N/A</i>		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Katherine C. White MD Staff Neonatologist</i>		29c. LICENSE NUMBER <i>D28737</i>		29d. DATE SIGNED (Month, Day, Year) <i>11/8/94</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Katherine C. White MD Holy Cross Hosp. 1500 Forest Glen Rd Silver Spring MD 20910</i>									
31. DATE FILED (Month, Day, Year) <i>NOV 16 1994</i>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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Item 20b, c, Film 717, 11/19/94, 1t

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CARLOS ALEX SPENCE SR.				2. DATE OF DEATH MONTH DAY YEAR NOV 15 1994		3. TIME OF DEATH 1:03 AM		
4. SOCIAL SECURITY NUMBER 213-70-3790		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 29 YRS.		7. DATE OF BIRTH (Month, Day, Year) JAN. 7, 1965		8. BIRTHPLACE (State or Foreign Country) MARYLAND	
9a. FACILITY NAME (If not institution, give street and number) JOHNS HOPKINS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH n/a		
RESIDENCE OF DECEDENT								
10a. STATE MARYLAND		10b. COUNTY n/a		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STREET AND NUMBER 4000 FRANKFORD AVENUE				10f. ZIP CODE 21206		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES		
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 TH College (1-4 or 5+) -		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LABORER/SPRINKLER		16b. KIND OF BUSINESS/INDUSTRY CONSTRUCTION				
17. FATHER'S NAME (First, Middle, Last) ALEXANDER SPENCE				18. MOTHER'S NAME (First, Middle, Maiden Surname) VIOLET THANIEL				
19a. INFORMANT'S NAME (Type/Print) VIOLET SPENCE				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4000 FRANKFORD, BALTIMORE, MD 21206				
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of King Memorial Park GARRISON FOREST VA CEMETERY 11-18 OWINGS MILLS, MD		20c. LOCATION — City or Town, State Baltimore		20d. DATE 11-18		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY WM C. MARCH FH.-1101 E. NORTH AVENUE				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple Gun shot wounds DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):								
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) 11-15-94		28b. TIME OF INJURY 0035 M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
		28d. DESCRIBE NOW INJURY OCCURED subject shot		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Roadway		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 14006bk Montford Rd Baltimore City		
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) NOV 15, 1994		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David R Fowler 111 Penn Street, Baltimore, Maryland 21201								
31. DATE FILED (Month, Day, Year) NOV 16 1994				32. REGISTRAR'S SIGNATURE 				

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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94 33766

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) BERNICE STEWART				2. DATE OF DEATH MONTH 11 DAY 16 YEAR 94		3. TIME OF DEATH 1417 M	
4. SOCIAL SECURITY NUMBER 218-30-7467		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 58 YRS.		7. DATE OF BIRTH (Month, Day, Year) 8/18/36	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9. COUNTY OF DEATH			
9a. FACILITY NAME (If not institution, give street and number) HARBOR HOSPITAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH BALTO. CITY		9c. COUNTY OF DEATH	
10a. STATE Md.		10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 310 Berlin Ave.				10f. ZIP CODE 21225		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (13-16) 4+		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) Lawrence Spencer				18. MOTHER'S NAME (First, Middle, Maiden Surname) Beatrice Queen			
19a. INFORMANT'S NAME (Type/Print) Garnell Stewart				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 310 Berlin Ave, Baltimore MD 21225			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Rest Cemetery		20c. LOCATION — City or Town, State Harmans MD		20d. NAME AND ADDRESS OF FACILITY (Name and address of funeral home) 1206 W. North Ave. Brown Funeral Baltimore, MD 21217	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE W. Brown				22. NAME AND ADDRESS OF FACILITY (Name and address of funeral home) 1206 W. North Ave. Brown Funeral Baltimore, MD 21217			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → INTRACEREBRAL BLEED							
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. HYPERTENSION							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Vanantia Vai P				29c. LICENSE NUMBER Home Staff		29d. DATE SIGNED (Month, Day, Year) 11/6/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) V. Vai HARBOR HOSPITAL CENTER							
31. DATE FILED (Month, Day, Year) NOV 16 1994		32. REGISTRAR'S SIGNATURE John S. ...					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33767

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Thomas HENRY Singleton SR.				2. DATE OF DEATH MONTH DAY YEAR Nov. 09, 1994		3. TIME OF DEATH 11:25 A M	
4. SOCIAL SECURITY NUMBER 218-10-5906		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 95 YRS.		7. DATE OF BIRTH (Month, Day, Year) AUG. 02, 1899	
9a. FACILITY NAME (If not institution, give street and number) MARYLAND GENERAL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH BALTIMORE	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION BALTIMORE CITY		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10a. STREET AND NUMBER 911 LEADENHALL, APT. #412				10f. ZIP CODE 21230		10g. CITIZEN OF WHAT COUNTRY? USA.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) UNKNOWN		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DISPATCHER		15b. KIND OF BUSINESS/INDUSTRY UNION HALL			
17. FATHER'S NAME (First, Middle, Last) UNKNOWN				18. MOTHER'S NAME (First, Middle, Maiden Surname) LILLIAN UNKNOWN			
19a. INFORMANT'S NAME (Type/Print) HILDA SINGLETON				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 911 LEADENHALL, APT. #412, BALTIMORE, MD. 21230			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT. ZION CEMETERY 11/15/94		20c. LOCATION — City or Town, State BALTIMORE, MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTIMORE, MD. 21223			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Respiratory Failure							
a. DUE TO (OR AS A CONSEQUENCE OF):							
b. Sepsis, Gangrene Right Foot							
c. Social Decubital Ulcer Infected							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Throat Cancer, Hypertension							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER James Mathew M.D.				29c. LICENSE NUMBER M14348		29d. DATE SIGNED (Month, Day, Year) 11-09-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) James Mathew, M.D. c/o Maryland General Hospital							
31. DATE FILED (Month, Day, Year) NOV 16 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

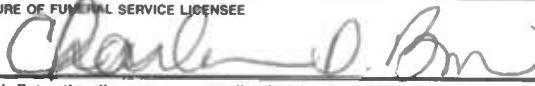
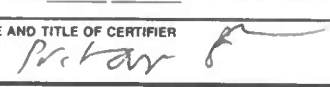
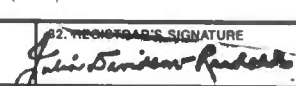
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33768

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Lloyd Arthur Severns				2. DATE OF DEATH MONTH DAY YEAR November 9, 1994		3. TIME OF DEATH 2055	
4. SOCIAL SECURITY NUMBER 191-03-5465		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 86 YRS.		7. DATE OF BIRTH (Month, Day, Year) 11-27-1907	
9a. FACILITY NAME (If not institution, give street and number) DEATON NURSING HOME				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH BALTIMORE	
10a. STATE MARYLAND				10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION BALTIMORE CITY	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 601 B BRIDGEVIEW ROAD			
10f. ZIP CODE 21225				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6th GRADE College (1-4 or 5+) BOILER TECHNICIAN				16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) GAS & ELECTRIC COMPANY			
17. FATHER'S NAME (First, Middle, Last) ARTHUR SEVERNS				18. MOTHER'S NAME (First, Middle, Maiden Surname) AGNES GILE			
19a. INFORMANT'S NAME (Type/Print) JACQUELINE SMITH				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 736 DEACON HILL COURT, BALTIMORE, MARYLAND 21225			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT. ZION CEMETERY		20c. LOCATION — City or Town, State 11-15-94 BALTIMORE, MARYLAND		22. NAME AND ADDRESS OF FACILITY JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTIMORE, MD 21223	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → multiple decubiti Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST cerebrovascular disease PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. severe decubiti pressure			
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER 228998		29d. DATE SIGNED (Month, Day, Year) 11-10-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PRITAN S SAANI MD 9101 Cherry Ln #211 LAUREL MD 210							
31. DATE FILED (Month, Day, Year) NOV 16 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33769

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Marie Bertha Shipley				2. DATE OF DEATH MONTH DAY YEAR Nov. 9, 1994		3. TIME OF DEATH 1:03 A. M	
4. SOCIAL SECURITY NUMBER 217 16 0083		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) 9/22/1917	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) 1002 Courtland Drive		9b. CITY, TOWN OR LOCATION OF DEATH Sykesville	
9c. COUNTY OF DEATH jCarroll				10a. STATE Md.			
10b. COUNTY Baltimore				10c. CITY, TOWN OR LOCATION Baltimore			
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 6412 Windsor Mill Road			
10f. ZIP CODE 21207				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) H.S.		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Home			
17. FATHER'S NAME (First, Middle, Last) Frederick Koester				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Gertrude Brannan			
19a. INFORMANT'S NAME (Type/Print) Marie Goodale				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1002 Courtland Dr. Sykesville, Md. 21784			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Carroll Cremation Service 11/9/94 Hampstead, Md.		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Harry W. Haight</i>				22. NAME AND ADDRESS OF FACILITY Haight Funeral Home P.O. Box 195 Sykesville, Md. 21784			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. metastatic adenocarcinoma unknown primary DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death 2 months.
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Yvonne Ottaviano MD</i>				29c. LICENSE NUMBER D40850		29d. DATE SIGNED (Month, Day, Year) 11/9/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) YVONNE OTTAVIANO 900 CATON AVE BALTIMORE MD							
31. DATE FILED (Month, Day, Year) NOV 15 1994				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33770

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) STELLA R. TIPTON				2. DATE OF DEATH MONTH 11 DAY 13 YEAR 94		3. TIME OF DEATH 3:10	
4. SOCIAL SECURITY NUMBER 212-09-7455		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 79 YRS.	7. DATE OF BIRTH (Month, Day, Year) 02 13 15		8. BIRTHPLACE (State or Foreign Country) MARYLAND	
9a. FACILITY NAME (If not institution, give street and number) 515 UPTON ROAD				9b. CITY, TOWN OR LOCATION OF DEATH 21144		9c. COUNTY OF DEATH ANNE ARUNDEL	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY ANNE ARUNDEL		10c. CITY, TOWN OR LOCATION SEVERN		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 515 UPTON ROAD				10f. ZIP CODE 21144		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE		16b. KIND OF BUSINESS/INDUSTRY HOMEMAKER			
17. FATHER'S NAME (First, Middle, Last) JAN KOZLOWSKI				18. MOTHER'S NAME (First, Middle, Maiden Surname) ZOFIA HELINSKI			
19a. INFORMANT'S NAME (Type/Print) DANIEL A. TIPTON				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 511 UPTON ROAD-SEVERN, MARYLAND 21144			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of place, crematory, or other place) HOLY CROSS CEMETERY 11/17		20c. LOCATION — City or Town, State BROOKLYN PARK, MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Daniel L. Kaufman</i>				22. NAME AND ADDRESS OF FACILITY RAYMOND C. FINK FUNERAL HOME 21061 426 CRAIN HWY. S.W. GLEN BURNIE, MD.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Ventricular Fibrillation, due to</i> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Coronary Artery Disease</i> <i>with Atrial Fibrillation</i> <i>due to Hypertension</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetes Mellitus Type II</i>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO N/A	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>		29c. LICENSE NUMBER DO283		29d. DATE SIGNED (Month, Day, Year) 11/14/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ANASTACIO E. SUBONG JR. - 206 CRAIN HWY. S.W. - GLEN BURNIE, MD. 21061							
31. DATE FILED (Month, Day, Year) NOV 16 1994				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


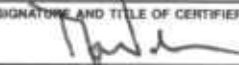

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33771

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) NORMA A. TAYLOR				2. DATE OF DEATH MONTH DAY YEAR Nov 5, 1994		3. TIME OF DEATH 3:06 M	
4. SOCIAL SECURITY NUMBER 217-20-4289		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 6, 1909	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) University Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH				10a. STATE Maryland		10b. COUNTY Baltimore	
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 2918 Parkwood Avenue	
10f. ZIP CODE 21217				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Domestic		16b. KIND OF BUSINESS/INDUSTRY Hutzler Family	
17. FATHER'S NAME (First, Middle, Last) Ralph Campbell				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sophonina Washington			
19a. INFORMANT'S NAME (Type/Print) Robert Taylor				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3604 Belle Avenue Baltimore, Maryland 21215			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arbutus Memorial Park 11/9		20c. LOCATION — City or Town, State Baltimore County, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, Inc 2501 Gwynns Falls Parkway Baltimore, Maryland 21216			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Aortic Dissection DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. Hypertension DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER 006015		29d. DATE SIGNED (Month, Day, Year) Nov 10 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Department Surgery University of Maryland Medical Systems							
31. DATE FILED (Month, Day, Year) NOV 16 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33772

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) HATTIE LEE TRACY				2. DATE OF DEATH MONTH Nov DAY 13 YEAR 94		3. TIME OF DEATH 9 25 P M	
4. SOCIAL SECURITY NUMBER 212-22-7403		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		7. DATE OF BIRTH (Month, Day, Year) 5/24/22	
9a. FACILITY NAME (If not institution, give street and number) Stella Maris				9b. CITY, TOWN OR LOCATION OF DEATH Towson		9c. COUNTY OF DEATH Balto.	
RESIDENCE OF DECEASED				10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10a. STATE Md.		10b. COUNTY		10e. STREET AND NUMBER 5813 Moores Run Ct.		10f. ZIP CODE 21206	
10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: Black		15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Library Aide		16b. KIND OF BUSINESS/INDUSTRY Balto. Co. P.S.	
17. FATHER'S NAME (First, Middle, Last) Clarence Cox				18. MOTHER'S NAME (First, Middle, Maiden Surname) Georgianna Daniels			
19a. INFORMANT'S NAME (Type/Print) Janet E. Tracy				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5813 Moores Run Ct. Balto., Md. 21206			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arbutus		20c. LOCATION — City or Town, State Balto, Md.		20d. DATE 11/17	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE James A. Morton				22. NAME AND ADDRESS OF FACILITY James A. Morton & Sons 1701 Laurens St. Balto., Md. 21217			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. RENAL FAILURE DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate interval between Onset and Death 6 mos.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CONGESTIVE HEART FAILURE							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) HOSPICE					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Kendall R Faulkner				29c. LICENSE NUMBER D25643		29d. DATE SIGNED (Month, Day, Year) 11/14/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. KENDALL FAULKNER 2300 DULANEY VALLEY ROAD TOWSON, MD 21204							
31. DATE FILED (Month, Day, Year) NOV 16 1994				32. REGISTRAR'S SIGNATURE John S. Anderson-Russell			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33773

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Lenn E. Thornton				2. DATE OF DEATH MONTH 11 DAY 11 YEAR 94		3. TIME OF DEATH 3:55 A.M.	
4. SOCIAL SECURITY NUMBER 214-68-472		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 36 YRS.		7. DATE OF BIRTH (Month, Day, Year) 7-2-58	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) BAYVIEW HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY	
9c. COUNTY OF DEATH n/a				10a. STATE MARYLAND			
10b. COUNTY n/a				10c. CITY, TOWN OR LOCATION BALTIMORE			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 509 MC CABE AVENUE			
10f. ZIP CODE 21212				10g. CITIZEN OF WHAT COUNTRY? UNITED STATES			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 TH College (1-4 or 5+) -				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) VENDER		16b. KIND OF BUSINESS/INDUSTRY VENDING COMPANY	
17. FATHER'S NAME (First, Middle, Last) THOMAS H. THORNTON				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY HOLLEY			
19a. INFORMANT'S NAME (Type/Print) MARY HOLLEY				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 509 MC CABE AVENUE, BALTIMORE, MD 21212			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) KING MEMORIAL PARK 11-17		20c. LOCATION — City or Town, State RANDALLSTOWN, MD		21. SIGNATURE OF FUNERAL SERVICE LICENSEE Karen M. Koger	
22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101E. NORTH AVENUE		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acquired Immune Deficiency DUE TO (OR AS A CONSEQUENCE OF): Urosepsis DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death > 2 yrs 30					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO						DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER Lenn E. Thornton		29c. LICENSE NUMBER D45929		29d. DATE SIGNED (Month, Day, Year) NOV 16 1994		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	
31. DATE FILED (Month, Day, Year) NOV 16 1994		32. REGISTRAR'S SIGNATURE John S. Anderson					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CHARLES MARK THOMPSON				2. DATE OF DEATH MONTH DAY YEAR NOV. 11 1994		3. TIME OF DEATH 1200 Noon	
4. SOCIAL SECURITY NUMBER 215-68-5370		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 37 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 2, 1957	
9a. FACILITY NAME (If not institution, give street and number) 2300 Birmingham Court				9b. CITY, TOWN OR LOCATION OF DEATH Madonna		9c. COUNTY OF DEATH Harford	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore City		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 912-N. Calvert Street				10f. ZIP CODE 21218		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Flight Attendant		16b. KIND OF BUSINESS/INDUSTRY Airlines			
17. FATHER'S NAME (First, Middle, Last) J. Roger Thompson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Burkins			
19a. INFORMANT'S NAME (Type/Print) Christopher Gilmartin				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 711 Brinkwood Road, Baltimore, Maryland 21229			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Green Mount Crematory Nov. 14 Baltimore, Maryland		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home 6500 York Rd. Baltimore, Maryland 21212			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acquired Immunodeficiency Syndrome DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO NA							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D31575		29d. DATE SIGNED (Month, Day, Year) 11/12/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) KULODRUBETZ 9501 Old Annapolis Rd Ellicott City MD 21042							
31. DATE FILED (Month, Day, Year) NOV 16 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760
 BALTIMORE, MARYLAND 21215-0020
 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as a burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33775

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) VERNON F TROXELL				2. DATE OF DEATH MONTH DAY YEAR 11 14 1994		3. TIME OF DEATH 12:05 A M	
4. SOCIAL SECURITY NUMBER 721 18 6438		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 68 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 12, 1926	
9a. FACILITY NAME (If not institution, give street and number) Greater Balto. Medical Center				9b. CITY, TOWN OR LOCATION OF DEATH Towson		9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT							
10a. STATE Md.		10b. COUNTY Carroll		10c. CITY, TOWN OR LOCATION Westminster		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 2611 Sykesville Road				10f. ZIP CODE 21157		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Bldg. Maintenance Supervisor		16b. KIND OF BUSINESS/INDUSTRY State Hwy. Admin.			
17. FATHER'S NAME (First, Middle, Last) Charles Roland Troxell				18. MOTHER'S NAME (First, Middle, Maiden Surname) Helen M. Sharer			
19a. INFORMANT'S NAME (Type/Print) Eresell C. Troxell				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2611 Sykesville Rd. Westminster, Md. 21157			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Tabor Cemetery November 16, 1994		20c. LOCATION — City or Town, State Rocky Ridge, Md			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Brian Haylett				22. NAME AND ADDRESS OF FACILITY Haight Funeral Home P.O. Box 195 Sykesville, Md. 21784			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Hemoptysis DUE TO (OR AS A CONSEQUENCE OF):				Approximate Interval Between Onset and Death 4 hrs	
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		b. Metastatic Carcinoma to lung DUE TO (OR AS A CONSEQUENCE OF):				6 mon.	
		c. Salivary gland Carcinoma DUE TO (OR AS A CONSEQUENCE OF):				1 yr	
		d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Charles Robert Troxell				29c. LICENSE NUMBER D15546		29d. DATE SIGNED (Month, Day, Year) 11-14-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Charles Robert Troxell, 5601 Loch Raven Blvd., Baltimore MD 21239							
31. DATE FILED (Month, Day, Year) NOV 15 1994		32. REGISTRAR'S SIGNATURE H. American Redell					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

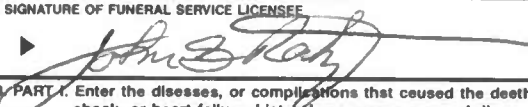
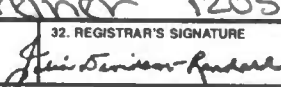
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33776

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Lillian Leona Voris				2. DATE OF DEATH MONTH DAY YEAR Nov. 6 1994		3. TIME OF DEATH 8:30 PM	
4. SOCIAL SECURITY NUMBER 212-10-0400		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) November 6, 1911	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. CITY, TOWN OR LOCATION OF DEATH Cockeysville		9c. COUNTY OF DEATH Baltimore	
9b. FACILITY NAME (If not institution, give street and number) Maryland Masonic Homes				10a. STATE Maryland		10b. COUNTY Baltimore	
10c. CITY, TOWN OR LOCATION Cockeysville				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 300 International Circle	
10f. ZIP CODE 21030				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Telephone Company		16b. KIND OF BUSINESS/INDUSTRY Telephone Company	
17. FATHER'S NAME (First, Middle, Last) James A. Pitcher				18. MOTHER'S NAME (First, Middle, Maiden Surname) Leona Etta Taylor			
19a. INFORMANT'S NAME (Type/Print) Roland C. Voris, Jr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4009 Security Lane, Jarrettsville, Maryland 21084			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parkwood Cemetery Nov. 9, Baltimore, Maryland		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home 6500 York Rd. Baltimore, Maryland 21212			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → myocardial infarction DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Parkinson's disease							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER June E Breiner MD				29c. LICENSE NUMBER D40208		29d. DATE SIGNED (Month, Day, Year) Nov. 10 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) June E Breiner 1205 York Rd Ste 32c Lutherville Md							
31. DATE FILED (Month, Day, Year) NOV 16 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33777

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Margaret Roberts Volpel</i>				2. DATE OF DEATH MONTH DAY YEAR <i>Nov. 13, 1994</i>		3. TIME OF DEATH <i>2:55 P M</i>	
4. SOCIAL SECURITY NUMBER <i>368-22-3245</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>86</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>June 21, 1908</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Greater Baltimore Medical Center</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Towson</i>		9c. COUNTY OF DEATH <i>Baltimore</i>	
RESIDENCE OF DECEDENT							
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Baltimore</i>		10c. CITY, TOWN OR LOCATION <i>Towson</i>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>800 Southerly Road</i>				10f. ZIP CODE <i>21286</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>5+</i> College (1-4 or 5+) <i>5+</i>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Own Home</i>			
17. FATHER'S NAME (First, Middle, Last) <i>William Timms Roberts</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Emily Alberta Margaret Graham</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Kathi Weinel</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>32 Oakway Road Timonium, Maryland 21093</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Dulaney Valley Memorial Gardens Nov. 16</i>		20c. LOCATION — City or Town, State <i>Timonium, Maryland</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dennis Stephen Xenakis</i>		22. NAME AND ADDRESS OF FACILITY <i>Mitchell-Wiedefeld Home Inc. 6500 York Rd. Baltimore, MD 21212</i>					
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>cardiopulmonary arrest</i> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <i>myocardial infarction</i> c. <i>CVA</i>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Robert Stoltz, MD</i>				29c. LICENSE NUMBER <i>D30910</i>		29d. DATE SIGNED (Month, Day, Year) <i>11/15/94</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Robert Stoltz, MD 1447 York Rd. Lutherville</i>							
31. DATE FILED (Month, Day, Year) <i>NOV 16 1994</i>				32. REGISTRAR'S SIGNATURE <i>John T. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33778

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CORNELIUS AVERY				2. DATE OF DEATH MONTH NOV. DAY 6 , YEAR 1994		3. TIME OF DEATH 2225 P M	
4. SOCIAL SECURITY NUMBER 217-26-1636		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 66 YRS.		7. DATE OF BIRTH (Month, Day, Year) 1/22/28	
8. BIRTHPLACE (State or Foreign Country) MD				9. COUNTY OF DEATH BALTIMORE			
10a. FACILITY NAME (If not institution, give street and number) SINAI HOSPITAL				10b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE			
10c. STATE MD				10d. COUNTY BALTIMORE			
10e. STREET AND NUMBER 1231 BEAUMONT AVE.				10f. ZIP CODE 21239		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: AFR. AMERICAN	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12 College (1-4 or 5+) 		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) RETIRED		16b. KIND OF BUSINESS/INDUSTRY U.S. ARMY			
17. FATHER'S NAME (First, Middle, Last) OSCAR AVERY				18. MOTHER'S NAME (First, Middle, Maiden Surname) GENEVA LEE AVERY			
19a. INFORMANT'S NAME (Type/Print) EUNICE WARD				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1231 BEAUMONT AVE. BALTO. MD 21239			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) METRO CREMATORY 11/9/94		20c. LOCATION — City or Town, State CATONSVILLE, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PLACE BALTO. MD 21217			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO INSPECTION							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER Margarita Korell M.D.		29c. LICENSE NUMBER O.C.M.E.	
29d. DATE SIGNED (Month, Day, Year) NOV. 7, 1994		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Margarita Korell M.D. 111 PENN STREET, BALTO. MD					
31. DATE FILED (Month, Day, Year) NOV 17 1994		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

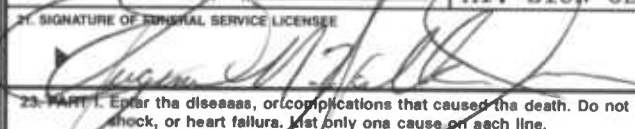

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

87788 49

94 33779

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) JANICE ELAINE FLEET ANDERSON				2. DATE OF DEATH MONTH 11 DAY 9 YEAR 94		3. TIME OF DEATH 0340 a M	
4. SOCIAL SECURITY NUMBER 215-70-4309		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 36 YRS.		7. DATE OF BIRTH (Month, Day, Year) 6/7/58	
9a. FACILITY NAME (If not institution, give street and number) UNIVERSITY HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTO.		9c. COUNTY OF DEATH MD	
10a. STATE MD				10b. COUNTY BALTO.		10c. CITY, TOWN OR LOCATION BALTO.	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 2361 ANNAPOLIS RD.			
10f. ZIP CODE 21230				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: AFR. AMERICAN	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HAIR STYLIST		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) BELMAR FLEET				18. MOTHER'S NAME (First, Middle, Maiden Surname) MABEL WALLACE			
19a. INFORMANT'S NAME (Type/Print) DAVID H. ANDERSON				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2361 ANNAPOLIS RD. BALTO. MD 21230			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation to <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place) MT. ZION CEM. 11/12/94		20c. LOCATION — City or Town, State BALTO. MD		22. NAME AND ADDRESS OF FACILITY ESTEP BROS. FUNERAL HOME P.A. 1300 EUTAW PLACE BALTO. MD 21217	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY ESTEP BROS. FUNERAL HOME P.A. 1300 EUTAW PLACE BALTO. MD 21217			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → SEPSIS DUE TO (OR AS A CONSEQUENCE OF): AIDS DUE TO (OR AS A CONSEQUENCE OF): HIV Infection DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST						Approximate Interval Between Onset and Death 2 dys 2 yrs 8 yrs	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO						DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER V.A. ROSE MD				29c. LICENSE NUMBER D46757		29d. DATE SIGNED (Month, Day, Year) 11-9-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) V.A. ROSE MD c/o University Hospital, Baltimore MD							
31. DATE FILED (Month, Day, Year) NOV 17 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33780

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) VINCENT F. ANDREONE				2. DATE OF DEATH MONTH 11 DAY 11 YEAR 94		3. TIME OF DEATH 1625 P M	
4. SOCIAL SECURITY NUMBER 215-14-9101		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 81 YRS.		7. DATE OF BIRTH 9-2-1913	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Sinai Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH				10a. STATE Md.			
10b. COUNTY				10c. CITY, TOWN OR LOCATION Baltimore			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 1820 Spence St.			
10f. ZIP CODE 21230				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Roofer		16b. KIND OF BUSINESS/INDUSTRY James Horn Roofing Co.			
17. FATHER'S NAME (First, Middle, Last) Alphonsus Andreone				18. MOTHER'S NAME (First, Middle, Maiden Surname) Claudina Tarantelli			
19a. INFORMANT'S NAME (Type/Print) Ruby L. Andreone				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1820 Spence St., Balto., Md. 21230			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Crest Lawn Memorial Grnds. 11/15		20c. LOCATION — City or Town, State Sykesville, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Gary L. Kaufman				22. NAME AND ADDRESS OF FACILITY Gary L. Kaufman Funeral Home of Elk., Inc. 5695 Main St., Elkridge, Md. 21227			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sepsis Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Pneumonia b. Cybercise c. CHF d.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER M. J. M. MD				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 11/11/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) Sinai Hospital Belvedere & Green Spring							
31. DATE FILED (Month, Day, Year) NOV 17 1994				32. REGISTRAR'S SIGNATURE John Andrew Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33781

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JAMES S ABERTS				2. DATE OF DEATH MONTH 11 DAY 13 YEAR 94		3. TIME OF DEATH 03:45 PM	
4. SOCIAL SECURITY NUMBER 212 46 9113		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 50 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 4, 1944	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL ASSOCIATION		9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE	
9c. COUNTY OF DEATH A.A. COUNTY				10a. STATE Maryland		10b. COUNTY Anne Arundel	
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 345 Cresswell Road	
10f. ZIP CODE 21225				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: White				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7th College (1-4 or 5+) College			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) Roofers				16b. KIND OF BUSINESS/INDUSTRY Independent Contracting			
17. FATHER'S NAME (First, Middle, Last) James Milton Aberts				18. MOTHER'S NAME (First, Middle, Maiden Surname) Catherine Ruth Heuer			
19a. INFORMANT'S NAME (Type/Print) C. Ruth Aberts				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 345 Cresswell Road Baltimore, Maryland 21225			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Cedar Hill Cemetery 11/17			
20c. LOCATION — City or Town, State Baltimore, Maryland				21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dana M. Zmamiowski			
22. NAME AND ADDRESS OF FACILITY George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute Anterior Myocardial Infarction Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M			
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER Marc Okun			
29c. LICENSE NUMBER D28000				29d. DATE SIGNED (Month, Day, Year) 11/15/94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. MARC OKUN, M.D./203 HOSPITAL DRIVE #206/GLEN BURNIE, MD. 21061							
31. DATE FILED (Month, Day, Year) NOV 17 1994				32. REGISTRAR'S SIGNATURE Julia Anderson-Radall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33782

DSE

02:10 AM

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Glenn Eugene Barrick Jr.				2. DATE OF DEATH MONTH 11 DAY 15 YEAR 94		3. TIME OF DEATH 11:15 PM	
4. SOCIAL SECURITY NUMBER 219-03-3598		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct. 11, 1915	
8. BIRTHPLACE (State or Country) Carroll Co., MD				9a. FACILITY NAME (If not institution, give street and number) Carroll County General Hosp		9b. CITY, TOWN OR LOCATION OF DEATH Westminster	
9c. COUNTY OF DEATH Carroll				10a. STATE MD		10b. COUNTY Baltimore Co.	
10c. CITY, TOWN OR LOCATION Reisterstown				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 14202 Hanover Rd.	
10f. ZIP CODE 21136				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Carpenter		16b. KIND OF BUSINESS/INDUSTRY construction	
17. FATHER'S NAME (First, Middle, Last) Glenn E. Barrick Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Goldie Spencer			
19a. INFORMANT'S NAME (Type/Print) Hazel I. Barrick				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14202 Hanover Rd., Reisterstown, MD 21136			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hampstead Cemetery 11/18/94		20c. LOCATION — City or Town, State Hampstead, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Eline				22. NAME AND ADDRESS OF FACILITY 11824 Reisterstown Rd. Eline Funeral Home Reisterstown, MD 21136			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → acute Pulmonary Edema							
DUE TO (OR AS A CONSEQUENCE OF): acute myocardial infarction 1 day							
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. dilated ischemic Cardiomyopathy aortic stenosis, diabetes mellitus							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER D. Balana MD				29c. LICENSE NUMBER D23015		29d. DATE SIGNED (Month, Day, Year) 11/15/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DINESH S. KALARIA 217 WASHINGTON HIGH WESTMINSTER, MD 21157							
31. DATE FILED (Month, Day, Year) NOV 17 1994				32. REGISTRAR'S SIGNATURE			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33783

Item # 14 Film # G 716 11-21-94 N.A. Per Funeral home

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) AKA Marie W. Bellegas <i>Marie W. Bellegas</i>				2. DATE OF DEATH MONTH 11 DAY 12 YEAR 94		3. TIME OF DEATH 1340 PM	
4. SOCIAL SECURITY NUMBER 219-32-2256		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 100 YRS.		7. DATE OF BIRTH (Month, Day, Year) 5/23/1894	
8. FACILITY NAME (If not institution, give street and number) Mercy Hospital Center				9b. CITY, TOWN OR LOCATION OF DEATH Balto. City, Md.		9c. COUNTY OF DEATH -----	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY -----		10c. CITY, TOWN OR LOCATION Balto. City, Md.		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1438 S. Charles St.				10f. ZIP CODE 21230		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White Chinese	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) None		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Owner		16b. KIND OF BUSINESS/INDUSTRY Restaurant			
17. FATHER'S NAME (First, Middle, Last) Unknown Jones				18. MOTHER'S NAME (First, Middle, Maiden Surname) Unknown			
19a. INFORMANT'S NAME (Type/Print) Mr. Arthur B. Wong				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1438 S. Charles St. Baltimore, Md. 21230			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Loudon Park Cemetery 11/15		20c. LOCATION — City or Town, State Balto. City, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>David A. Hayler</i>				22. NAME AND ADDRESS OF FACILITY Balto. Md. 21230 McCully Funeral Home. 130 E. Fort Ave			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pneumonia DUE TO (OR AS A CONSEQUENCE OF): Bullous Emphysema DUE TO (OR AS A CONSEQUENCE OF): Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 1 wk				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>David F. Patrick, MD</i> Medical Resident				29c. LICENSE NUMBER 06142		29d. DATE SIGNED (Month, Day, Year) 11/12/94					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David F. Patrick, MD				31. DATE FILED (Month, Day, Year) NOV 17 1994							
32. REGISTRAR'S SIGNATURE <i>John Benison</i>											

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33784

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) VERONICA BRZUCHALSKI				2. DATE OF DEATH MONTH 11 DAY 15 YEAR 94		3. TIME OF DEATH 5 P M	
4. SOCIAL SECURITY NUMBER 217-16-4598		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 65 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH 10-11-1929	
8. BIRTHPLACE (State) Maryland				9. COUNTY OF DEATH BALTIMORE		10. CITY, TOWN OR LOCATION OF DEATH BALTIMORE	
11. FACILITY NAME (If not institution, give street and number) HARBOR HOSPITAL CENTER				12. RESIDENCE OF DECEDENT BALTIMORE		13. COUNTY OF DEATH N/A	
14a. STATE MARYLAND		14b. COUNTY Anne Arundel		14c. CITY, TOWN OR LOCATION BALTIMORE		14d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
15. STREET AND NUMBER 5932, BELLE GROVE RD				16. ZIP CODE 21225		17. CITIZEN OF WHAT COUNTRY? USA	
18. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		19. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		20. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		21. RACE — American Indian, Black, White, etc. Specify: WHITE	
22. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (1-4 or 5+) N/A		23. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) NONE		24. KIND OF BUSINESS/INDUSTRY NONE			
25. FATHER'S NAME (First, Middle, Last) PETER BRZUCHALSKI				26. MOTHER'S NAME (First, Middle, Maiden Surname) MARY KARWACKI			
27. INFORMANT'S NAME Raymond J. Brzuchalski		28. MAILING ADDRESS 114 Nichols Manor Rd, Stevensville, Md 21155					
29. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		30. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HOLY CROSS CEMETERY 11/18/1994		31. LOCATION — City or Town, State BROOKLYN, MD.			
32. SIGNATURE OF FUNERAL SERVICE LICENSEE 				33. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W. GLEN BURNIE, MARYLAND 21061			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CARDIAC ARREST DUE TO (OR AS A CONSEQUENCE OF): a. CARDIAC ARREST b. DUE TO (OR AS A CONSEQUENCE OF): c. ENCEPHALOPATHY d. DUE TO (OR AS A CONSEQUENCE OF): SEQUENTIALLY LIST CONDITIONS, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
24. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		25. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
26. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		27. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
28. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		29. DATE OF INJURY (Month, Day, Year)		30. TIME OF INJURY M		31. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
32. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				33. DESCRIBE HOW INJURY OCCURRED			
34. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
35. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
36. SIGNATURE AND TITLE OF CERTIFIER Andra Poi INTERN, HARBOR HOSPITAL				37. LICENSE NUMBER		38. DATE SIGNED (Month, Day, Year) 11/15/94	
39. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) YESO-TI AMERICANA CIRCLE, GLEN BURNIE, MD 21060							
40. DATE FILED (Month, Day, Year) 11/15/NOV 17 1994				41. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

U.S. AIR FORCE

94 33785

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Ruth Tanner Brown				2. DATE OF DEATH MONTH 11 DAY 9 YEAR 94		3. TIME OF DEATH 5:00 pm	
4. SOCIAL SECURITY NUMBER 042-16-5391		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) February 11, 1915	
9a. FACILITY NAME (If not institution, give street and number) Fallston General Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Fallston		9c. COUNTY OF DEATH Harford	
10a. STATE Md.		10b. COUNTY Harford		10c. CITY, TOWN OR LOCATION Adingdon		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 422 Denton Way				10f. ZIP CODE 21009		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		15b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Hubert Tanner				18. MOTHER'S NAME (First, Middle, Maiden Surname) Laura Weare			
19a. INFORMANT'S NAME (Type/Print) Bob Brown				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 422 Denton Way, Abingdon, Md. 21009			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Autrey Cemetery 11/12		20c. LOCATION — City or Town, State Burnsville, N.C.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Gary L. Kaufman Funeral Home of Elk., Inc. 5695 Main St., Elkridge, Md. 21227			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. acute renal failure DUE TO (OR AS A CONSEQUENCE OF): b. atrial fibrillation DUE TO (OR AS A CONSEQUENCE OF): c. chronic obstructive pulmonary DUE TO (OR AS A CONSEQUENCE OF): d. congestive heart failure Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate interval between Onset and Death 48 hrs
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28b. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER P Dubyalski MD (P Dubyalski)				29c. LICENSE NUMBER D 29227		29d. DATE SIGNED (Month, Day, Year) 11/10/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Patricia A Dubyalski 1131 Belair Rd Bel Air Md 21014							
31. DATE FILED (Month, Day, Year) NOV 17 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Ruth Louise Boone				2. DATE OF DEATH MONTH DAY YEAR November 15, 1994				3. TIME OF DEATH 12 noon M	
4. SOCIAL SECURITY NUMBER 216-30-7256		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 61 YRS.		7. DATE OF BIRTH (Month, Day, Year) February 24, 1933		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) 17240 Hardy Road				9b. CITY, TOWN OR LOCATION OF DEATH Mt. Airy				9c. COUNTY OF DEATH Howard Co Carroll County	
RESIDENCE OF DECEDENT									
10a. STATE Maryland		10b. COUNTY Carroll County		10c. CITY, TOWN OR LOCATION Mt. Airy				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 17240 Hardy Road				10f. ZIP CODE 21771		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Dispatcher			16b. KIND OF BUSINESS/INDUSTRY Office Work		
17. FATHER'S NAME (First, Middle, Last) George W. Bloodsworth				18. MOTHER'S NAME (First, Middle, Maiden Surname) Louise M. Fleming					
19a. INFORMANT'S NAME (Type/Print) Mr. Daniel W. Boone				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17240 Hardy Road Mt. Airy, MD 21771					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lake View Mem. Park Nov. 18, 1994		20c. LOCATION — City or Town, State Sykesville, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ► Brian S. Haight				22. NAME AND ADDRESS OF FACILITY HAIGHT FUNERAL HOME (P.O. Box 195) Sykesville, MD 21784 (410)-795-1400					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic Breast Carcinoma Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER RONALD E. L. M. D.				29c. LICENSE NUMBER 026499	
29d. DATE SIGNED (Month, Day, Year) 11-16-94				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) JULIA D. BUCKLEY					
31. DATE FILED (Month, Day, Year) NOV 1 1994				32. REGISTRAR'S SIGNATURE 301-829-0222					

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

94 33787

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) RIDGELY BROWN BOND JR.				2. DATE OF DEATH MONTH DAY YEAR NOV. 16 1994		3. TIME OF DEATH 9:00 P. M.	
4. SOCIAL SECURITY NUMBER 212-09-5800		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 89 YRS.		7. DATE OF BIRTH (Month, Day, Year) JUNE 13, 1905	
8a. FACILITY NAME (If not institution, give street and number) 24 SEMINOLE AVENUE				9b. CITY, TOWN OR LOCATION OF DEATH CATONSVILLE		9c. COUNTY OF DEATH BALTIMORE	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION CATONSVILLE		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 24 SEMINOLE AVENUE				10f. ZIP CODE 21228		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+) 5+		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CHEMIST		16b. KIND OF BUSINESS/INDUSTRY SUGAR REFINING			
17. FATHER'S NAME (First, Middle, Last) RIDGELY BROWN BOND				18. MOTHER'S NAME (First, Middle, Maiden Surname) MIRIAM POE			
19a. INFORMANT'S NAME (Type/Print) MIRIAM KOPPEL (DAUGHTER)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24 SEMINOLE AVENUE CATONSVILLE MARYLAND 21228			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ARLINGTON NATIONAL CEMETERY 11-23-94		20c. LOCATION — City or Town, State ARLINGTON VIRGINIA			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Russell W. Witzke</i>				22. NAME AND ADDRESS OF FACILITY WITZKE FUNERAL HOMES P.A. 1630 EDMONDSON AVENUE CATONSVILLE MARYLAND 21228			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SUDDEN CORONARY DEATH 20 DUE TO (OR AS A CONSEQUENCE OF): b. TO SEVERE CORONARY DISEASE DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. POLYMYALGIA RHEUMATICA, CONGESTIVE HEART FAILURE, ATRIAL FIBRILLATION							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Alvin L. Kuhn MD</i>				29c. LICENSE NUMBER D21336		29d. DATE SIGNED (Month, Day, Year) 11/17/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ALVIN KUHN MD, 716 MARDEN CHASE LANE #205, BALTIMORE MD							
31. DATE FILED (Month, Day, Year) NOV 17 1994				32. REGISTRAR'S SIGNATURE <i>John D. Denson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Samuel D. Blum Samuel David Blum				2. DATE OF DEATH MONTH 11 DAY 12 YEAR 94		3. TIME OF DEATH 11 05 P M	
4. SOCIAL SECURITY NUMBER 217-03-1763		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 89 YRS.		7. DATE OF BIRTH (Month, Day, Year) 06/25/05	
9a. FACILITY NAME (If not institution, give street and number) Sinai Hospital - Baltimore, MD				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore, MD		9c. COUNTY OF DEATH Baltimore	
10a. STATE MD				10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Baltimore	
10d. INSIDE CITY LIMITS <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 2434 W. Belvedere Ave		10f. ZIP CODE 21215	
10g. CITIZEN OF WHAT COUNTRY? United States				11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) MANUFACTURER'S REPRESENTATIVE				16b. KIND OF BUSINESS/INDUSTRY WOMENS WEAR			
17. FATHER'S NAME (First, Middle, Last) MOSES BLUM				18. MOTHER'S NAME (First, Middle, Maiden Surname) FANNY HERZFELD			
19a. INFORMANT'S NAME (Type/Print) MS. ESTELLE BLUM				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21218 3935 CLOVERHILL ROAD BALTIMORE, MD 21215			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place) BETH TFILOH 11-16-94		20c. LOCATION — City or Town, State BALTIMORE, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pneumonia DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Urinary Tract Infection, Heart Disease							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Anthony S. Burns M.D.				29c. LICENSE NUMBER AS2402321AB98A		29d. DATE SIGNED (Month, Day, Year) 11/12/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Anthony Burns, M.D. Sinai Hospital - Baltimore MD							
31. DATE FILED (Month, Day, Year) NOV 17 1994				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

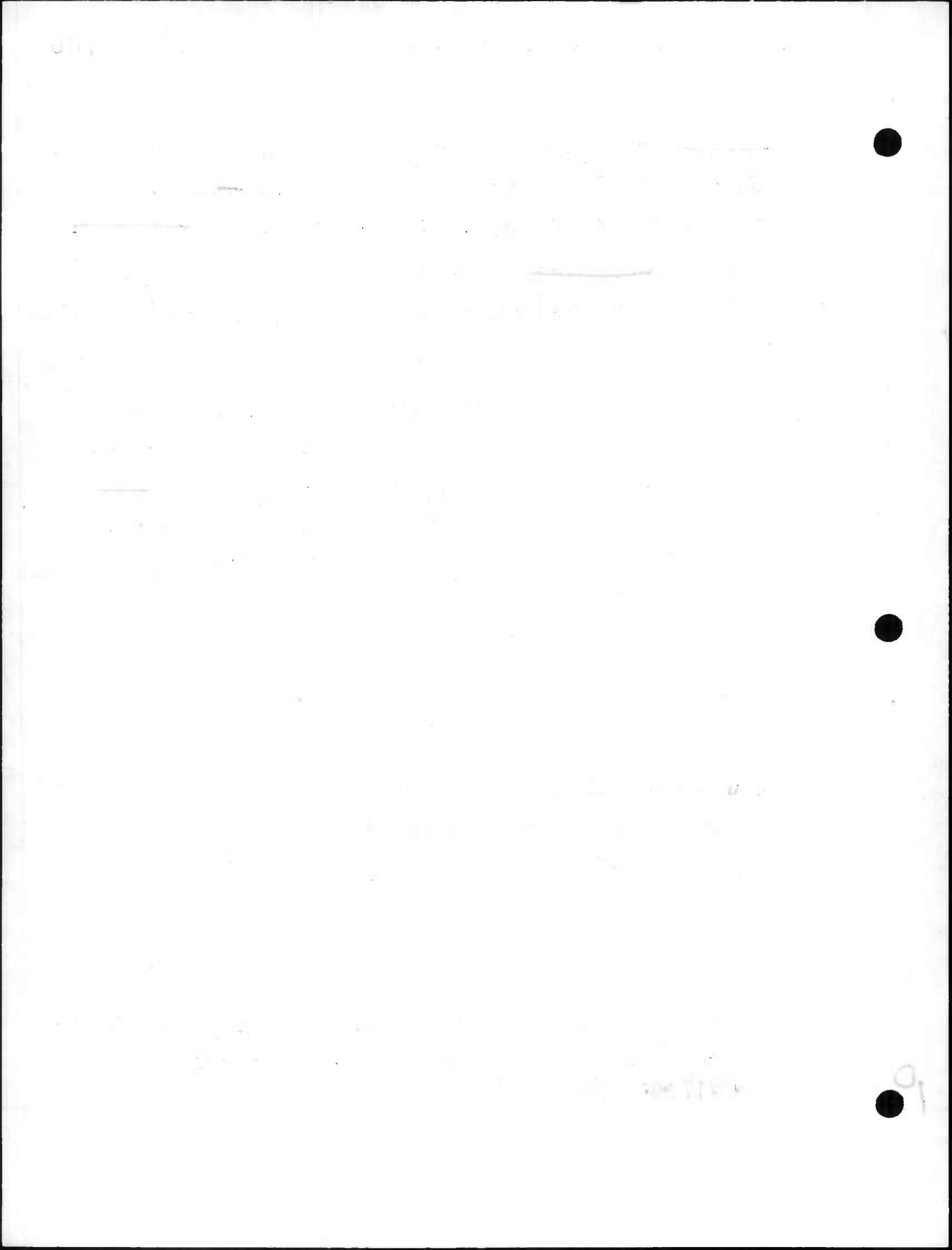
TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33789

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Nellie Marcella Baumgartner				2. DATE OF DEATH MONTH DAY YEAR November 14 1994		3. TIME OF DEATH 11:47 a.m.	
4. SOCIAL SECURITY NUMBER 220-44-5168		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (in yrs. last birthday) 94 YRS.		7. DATE OF BIRTH (Month, Day, Year) August 31, 1900	
9a. FACILITY NAME (If not institution, give street and number) 26 Hamill Court Apt. 26				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH	
10a. STATE Maryland				10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 26 Hamill Court Apt. 26		10f. ZIP CODE 21210	
10g. CITIZEN OF WHAT COUNTRY? United States				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5 +)	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker				16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) William Null				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ella Bishop			
19a. INFORMANT'S NAME (Type/Print) Mr. Joseph E. Baumgartner, Jr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 410 Winston Avenue Baltimore, Md. 21212			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. John's Church Cemetery 11/17/94		20c. LOCATION — City or Town, State Westminster, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Mark T. Zavoyna				22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, 21214			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → ASCVD							
Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Parkinsonism							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Alan Kimmel MD				29c. LICENSE NUMBER D25743		29d. DATE SIGNED (Month, Day, Year) 11/15/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 220W Cold Spring Lane 21210 Alan Kimmel MD							
31. DATE FILED (Month, Day, Year) NOV 17 1994				32. REGISTRAR'S SIGNATURE John Benson			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33790

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Lena Bradford				2. DATE OF DEATH MONTH DAY YEAR Nov. 10, 1994		3. TIME OF DEATH 4:15 P M	
4. SOCIAL SECURITY NUMBER 219-16-2971		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 80 YRS.	7. DATE OF BIRTH (Month, Day, Year) Jan. 23, 1914	8. BIRTHPLACE (State or Foreign Country) GEORGIA		
9a. FACILITY NAME (If not institution, give street and number) VILLA ST. MICHAEL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 908 NORTH AUGUSTA AVENUE				10f. ZIP CODE 21229		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired) HOMEMAKER		16b. KIND OF BUSINESS/INDUSTRY OWN HOME			
17. FATHER'S NAME (First, Middle, Last) THOMAS TALBOT				18. MOTHER'S NAME (First, Middle, Maiden Surname) LULA TALBOT			
19a. INFORMANT'S NAME (Type/Print) ROBERT BRADFORD				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 908 N. AUGUSTA AVE, BALTO, MD 21229			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ARBUTUS MEM. PK 11/14		20c. LOCATION — City or Town, State BALTO, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Joseph L. Russ</i>				22. NAME AND ADDRESS OF FACILITY JOSEPH L. RUSS FUNERAL HOME 2222 W. North Ave, Balto, MD. 21216			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cerebral Thrombosis DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death 1 week
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dr. Williams discussed and relevant to her							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Harold B. Burr</i> MD		29c. LICENSE NUMBER D15872		29d. DATE SIGNED (Month, Day, Year) 11-16-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HAROLD B. BURR MD 7220 Park Heights Ave 21208							
31. DATE FILED (Month, Day, Year) NOV 17 1994				32. REGISTRAR'S SIGNATURE <i>John Benson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

LETTERBOARD

THE DAY BEFORE

THE DAY AFTER

NEW YORK

94 33791

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ALBERT JOSEPH BUSCHMAN, JR.				2. DATE OF DEATH MONTH DAY YEAR 11-6-94		3. TIME OF DEATH 4:10A M	
4. SOCIAL SECURITY NUMBER 572 28 7360		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 63 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10-27-1931	
9a. FACILITY NAME (If not institution, give street and number) 13002 Blairmore Street				9b. CITY, TOWN OR LOCATION OF DEATH Beltsville		9c. COUNTY OF DEATH Prince George Co	
10a. STATE Maryland				10b. COUNTY Prince Geo Co		10c. CITY, TOWN OR LOCATION Beltsville	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 13002 Blairmore St			
10f. ZIP CODE 20705				10g. CITIZEN OF WHAT COUNTRY?			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES yes Navy 49-53		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 + College (1-4 or 5+) 4				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Physicist		16b. KIND OF BUSINESS/INDUSTRY Federal Gov't	
17. FATHER'S NAME (First, Middle, Last) Albert Joseph Buschman, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Alice Smith			
19a. INFORMANT'S NAME (Type/Print) Douglas Buschman				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11813 Quince Mill Dr, N.Potomac, MD			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		20c. LOCATION — City or Town, State		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ronald Wade, Dir</i>				22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655W. Baltimore St, Balto, MD 21201			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → hepatic failure a. DUE TO (OR AS A CONSEQUENCE OF) metastatic carcinoma b. DUE TO (OR AS A CONSEQUENCE OF) c. DUE TO (OR AS A CONSEQUENCE OF) d. DUE TO (OR AS A CONSEQUENCE OF) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Martin Weltz</i>		29c. LICENSE NUMBER 123743		29d. DATE SIGNED (Month, Day, Year) 11-10-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR MARTIN WELTZ 7525 Greenway Cnt Dr #205, Greenbelt, MD							
31. DATE FILED (Month, Day, Year) NOV 17 1994		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33792

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ROBERT H. CHRISTY				2. DATE OF DEATH MONTH DAY YEAR NOVEMBER 16, 1994				3. TIME OF DEATH 1:10 p.m.	
4. SOCIAL SECURITY NUMBER 181-18-8602		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7. DATE OF BIRTH (Month, Day, Year) 02/21/21				8. BIRTHPLACE (State or Foreign Country) PA.					
9a. FACILITY NAME (If not institution, give street and number) VA MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH FORT HOWARD				9c. COUNTY OF DEATH BALTIMORE	
RESIDENCE OF DECEDENT									
10a. STATE MD.		10b. COUNTY Balto. Co.		10c. CITY, TOWN OR LOCATION Randsallstown				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 8420 Charlton Rd.				10f. ZIP CODE 21133				10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II - Korea		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE - American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Engineer				16b. KIND OF BUSINESS/INDUSTRY MD. State Highway Comm.	
17. FATHER'S NAME (First, Middle, Last) Arthur H. Christy				18. MOTHER'S NAME (First, Middle, Maiden Surname) Jean Mac Millan					
19a. INFORMANT'S NAME (Type/Print) Mary P. Christy				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8420 Charlton Rd. Randallstown MD. 21133					
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory 11/17				20c. LOCATION - City or Town, State Catonsville MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dean L. Charlton				22. NAME AND ADDRESS OF FACILITY Charlton F.H. 2007 Eastern Ave. 21231					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SEPSIS SYNDROME DUE TO (OR AS A CONSEQUENCE OF): b. POLYMYOSITIS DUE TO (OR AS A CONSEQUENCE OF): c. PARAPLEGIA DUE TO (OR AS A CONSEQUENCE OF): d. RENAL FAILURE 2° to RENAL STONE Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO									
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
				28d. DESCRIBE HOW INJURY OCCURRED					
28e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER EDWARD OBAZEE, M.D.				29c. LICENSE NUMBER				29d. DATE SIGNED (Month, Day, Year) 11/16/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 21) (Type, Print) EDWARD OBAZEE, M.D., VA MEDICAL CENTER, FORT HOWARD, MD 21052									
31. DATE FILED (Month, Day, Year) NOV 17 1994				32. REGISTRAR'S SIGNATURE John F. Anderson					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33793

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) AKA <u>Joshua Allen Priola Carter</u>				2. DATE OF DEATH MONTH <u>11</u> DAY <u>7</u> YEAR <u>94</u>		3. TIME OF DEATH <u>12:15 p.m.</u>	
4. SOCIAL SECURITY NUMBER <u> </u>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. <u>12</u>		7. DATE OF BIRTH (Month, Day, Year) <u>11/7/94</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>University of Maryland Hospital</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore MD</u>		9c. COUNTY OF DEATH <u>Baltimore City</u>	
10a. STATE <u>Maryland</u>				10b. COUNTY <u>Baltimore City</u>		10c. CITY, TOWN OR LOCATION <u>Baltimore</u>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER <u>1737 Belt Street</u>				10f. ZIP CODE <u>21230</u>		10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u> </u> College (1-4 or 5+) <u> </u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u> </u>		16b. KIND OF BUSINESS/INDUSTRY <u> </u>			
17. FATHER'S NAME (First, Middle, Last) <u>Clifton Eugene Carter</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Edith Ruth Priola-Carter</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Edith Ruth Priola-Carter</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1737 Belt Street Baltimore MD 21230</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) <u>GLEN HAVEN mem. PARK 11-9-94</u>		20c. LOCATION — City or Town, State <u>GLEN BURNIE, Md.</u>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Vanida Noyes</u>				22. NAME AND ADDRESS OF FACILITY <u>Balto. Md. 21230 McGOLLY FUNERAL HOME - 130 E. Fort Ave</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <u>Pulmonary Hypoplasia</u> DUE TO (OR AS A CONSEQUENCE OF):					Approximate Interval Between Onset and Death <u>12h</u>
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. <u>Cystic-Dysplastic Kidneys</u> DUE TO (OR AS A CONSEQUENCE OF):					<u>12h</u>
		c. <u> </u> DUE TO (OR AS A CONSEQUENCE OF):					
		d. <u> </u> DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u> </u>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <u> </u>		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED <u> </u>				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <u> </u>			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <u> </u>							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Renee Ellen Fox MD</u>				29c. LICENSE NUMBER <u>D33573</u>		29d. DATE SIGNED (Month, Day, Year) <u>11/7/94</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>22 S. Greene Street, Baltimore MD 21201</u>							
31. DATE FILED (Month, Day, Year) <u>NOV 17 1994</u>				32. REGISTRAR'S SIGNATURE <u>John B. ...</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94-6636-003

UNK 94-212

L.R.B.

1 - STATE
REGISTRAR

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-718 12/12/94 t.t

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

94 33794

1. DECEDENT'S NAME (First, Middle, Last) CAROL CLINE				2. DATE OF DEATH MONTH DAY YEAR NOV 15 1994		3. TIME OF DEATH 11:10A M	
4. SOCIAL SECURITY NUMBER 216 42 8168		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) 50 YRS.		7. DATE OF BIRTH (Month, Day, Year) 08/19/1944	
9a. FACILITY NAME (If not institution, give street and number) A.A. COMMUNITY COLLEGE				9b. CITY, TOWN OR LOCATION OF DEATH Annold		9c. COUNTY OF DEATH Pennsylvania	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Annold		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 1277 Ritchie Highway Unit 200				10f. ZIP CODE 21012		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (13-16) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Nursing Assistant		16b. KIND OF BUSINESS/INDUSTRY Home Care			
17. FATHER'S NAME (First, Middle, Last) James Cline				18. MOTHER'S NAME (First, Middle, Maiden Surname) Grace Steele			
19a. INFORMANT'S NAME (Type/Print) Wanda Schlereth				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3014 Bero Road Baltimore, Maryland 21227			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory, Inc. 11/17		20c. LOCATION — City or Town, State Baltimore, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Richard E. Davis</i>				22. NAME AND ADDRESS OF FACILITY George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. THERMAL INJURY AND SMOKE INHALATION DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) WOODED AREA.					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) FOUND: 11/15/94		28b. TIME OF INJURY FOUND: 11:10 A M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) WOODED AREA		28e. DESCRIBE HOW INJURY OCCURRED SELF IMMOLATION			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Wanda Schlereth</i>		29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) NOV 16, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARY DORIS A. KORSMAN 111 Penn Street, Baltimore, Maryland 21201.							
31. DATE FILED (Month, Day, Year) NOV 17 1994		32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) DEBORAH M. CARTON				2. DATE OF DEATH MONTH 11 DAY 13 YEAR 94		3. TIME OF DEATH 0145A M	
4. SOCIAL SECURITY NUMBER 067-18-4805		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 71 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept 14, 1923	
8. BIRTHPLACE (State or Foreign Country) New York				9a. FACILITY NAME (If not institution, give street and number) Suburban Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Bethesda	
9c. COUNTY OF DEATH Montgomery				10a. STATE Maryland		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION Rockville				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 6111 Montrose Rd Apt 426	
10f. ZIP CODE 20852				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5+				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Teacher		16b. KIND OF BUSINESS/INDUSTRY Education	
17. FATHER'S NAME (First, Middle, Last) David Mendelsohn				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Solomon			
19a. INFORMANT'S NAME (Type/Print) Mr. PAUL CARTON				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 Shagbark Ct, Rockville, MD 20852			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Park 11/14/94		20c. LOCATION — City or Town, State Emerson, NJ	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Sol Levinson & Bros. 6010 Reisterstown Rd, Baltimore, MD 21215			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → pericarditis nonfatal - probable Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST e. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause, given in Part I. renal failure, heart failure, sepsis							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) At Home				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 11/13/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) NOV 17 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33796

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HOWARD W. DAWSON				2. DATE OF DEATH MONTH NOVEMBER DAY 15, 1994 YEAR		3. TIME OF DEATH 3:48 P M											
4. SOCIAL SECURITY NUMBER 212-22-1494		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 71 YRS.		7. DATE OF BIRTH (Month, Day, Year) NOV. 3, 1923											
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY											
9c. COUNTY OF DEATH n/a				10a. STATE MARYLAND													
10b. COUNTY n/a				10c. CITY, TOWN OR LOCATION BALTIMORE													
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 2715 DELK COURT													
10f. ZIP CODE 21222				10g. CITIZEN OF WHAT COUNTRY? UNITED STATES													
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK											
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 TH College (1-4 or 5+) M.S. - degree		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SCIENCE TEACHER		16b. KIND OF BUSINESS/INDUSTRY BALTIMORE CITY PUBLIC SCH.													
17. FATHER'S NAME (First, Middle, Last) WALKER H. DAWSON				18. MOTHER'S NAME (First, Middle, Maiden Surname) BESSIE DORSEY													
19a. INFORMANT'S NAME (Type/Print) LETHIA E. DAWSON				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2715 DELK COURT, BALTIMORE, MD 21222													
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GARRISON FOREST VA CEMETERY		20c. LOCATION — City or Town, State 11- OWINGS MILLS, MD		20d. DATE											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Vanessa Cox</i>				22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH. 1101 E. NORTH AVENUE													
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																	
IMMEDIATE CAUSE (Final disease or condition resulting in death) →																	
<table border="0"> <tr> <td rowspan="4">Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</td> <td>a.</td> <td>Rupture of Aortic Arch</td> <td rowspan="4">Approximate Interval Between Onset and Death 20 minutes 3 days 20 years</td> </tr> <tr> <td>b.</td> <td>Aortic dissection</td> </tr> <tr> <td>c.</td> <td>Cystic medial degeneration</td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>								Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	a.	Rupture of Aortic Arch	Approximate Interval Between Onset and Death 20 minutes 3 days 20 years	b.	Aortic dissection	c.	Cystic medial degeneration	d.	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	a.	Rupture of Aortic Arch	Approximate Interval Between Onset and Death 20 minutes 3 days 20 years														
	b.	Aortic dissection															
	c.	Cystic medial degeneration															
	d.																
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. None																	
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO																	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO																	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>																	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)															
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO											
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)													
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)																	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																	
29b. SIGNATURE AND TITLE OF CERTIFIER Dr Keith Robertson				29c. LICENSE NUMBER L9933		29d. DATE SIGNED (Month, Day, Year) 11/15/94											
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) KEITH ROBERTSON, Johns Hopkins Hospital																	
31. DATE FILED (Month, Day, Year) NOV 17 1994				32. REGISTRAR'S SIGNATURE <i>Johnston</i>													

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33797

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Jessie A. Dudgeon				2. DATE OF DEATH MONTH November DAY 13, 1994 YEAR				3. TIME OF DEATH 4:10 A.M. M					
4. SOCIAL SECURITY NUMBER 291-01-7188		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) 10-5-1914		8. BIRTHPLACE (State or Foreign Country) Ohio	
9a. FACILITY NAME (If not institution, give street and number) Pickersgill Home						9b. CITY, TOWN OR LOCATION OF DEATH Towson				9c. COUNTY OF DEATH Baltimore			
RESIDENCE OF DECEDENT													
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Towson				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER 615 Chestnut Ave.						10f. ZIP CODE 21204				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) College (1-4 or 5 +) 2				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Office Manager				16b. KIND OF BUSINESS/INDUSTRY Thompson's Of St. Clair					
17. FATHER'S NAME (First, Middle, Last) Glenn Babcock						18. MOTHER'S NAME (First, Middle, Maiden Surname) Lelia Huid							
19a. INFORMANT'S NAME (Type/Print) Mrs Jean L. Saunders						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 901 Hatherleigh Road, Baltimore, Maryland 21212							
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hilltop Service Corp. 11-14-94				DATE		20c. LOCATION — City or Town, State Towson, Maryland 21204			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Wallace S. Brooks Jr.						22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Amyotrophic Lateral sclerosis DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST												Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO												24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28i. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER Anthony Riley						29c. LICENSE NUMBER D25205				29d. DATE SIGNED (Month, Day, Year) 11/17/94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Anthony Riley, M.D. 6565 N. Charles Street, Towson, Md. 21204													
31. DATE FILED (Month, Day, Year) NOV 17 1994				32. REGISTRAR'S SIGNATURE John Davidson-Rudolph									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

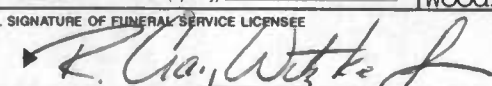


TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33798

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MADELINE T. EICHLER				2. DATE OF DEATH MONTH 11 DAY 14 YEAR 1994		3. TIME OF DEATH 8:30 P M	
4. SOCIAL SECURITY NUMBER 212-03-7478		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) Feb. 14, 1911	
9a. FACILITY NAME (If not institution, give street and number) Charlestown Care Center				9b. CITY, TOWN OR LOCATION OF DEATH Catonsville		9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Catonsville		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 701 Maiden Choice Lane				10f. ZIP CODE 21228		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) BOOKKEEPER		16b. KIND OF BUSINESS/INDUSTRY AWNING COMPANY			
17. FATHER'S NAME (First, Middle, Last) Godfrey Eichler				18. MOTHER'S NAME (First, Middle, Maiden Surname) Marian Grabner			
19a. INFORMANT'S NAME (Type/Print) Thomas F. Carroll (Nephew)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9511 Sea Turtle Manor Plantation Florida 33324			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Woodlawn Cemetery 11-17-94		DATE		20c. LOCATION — City or Town, State Woodlawn, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY Leroy M & Russell C Witzke Funeral Homes 1630 Edmondson Avenue Catonsville Maryland					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CONGESTIVE HEART FAILURE DUE TO (OR AS A CONSEQUENCE OF): b. MYOCARDIAL INFARCTION DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death Months 3 years Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC RENAL FAILURE 2° HEART BLOCK WITH PACEMAKER							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
29b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER D44748		29d. DATE SIGNED (Month, Day, Year) 11/15/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MATTHEW J. NARRETT 711 MAIDEN CHOICE LANE CATONSVILLE MD							
31. DATE FILED (Month, Day, Year) NOV 17 1994		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 38760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94-6582-510
B.K.S

Item 10g, Film 717, 11/17/94, 1t

94 33799

FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) RICHARD T. FRAZIER				2. DATE OF DEATH MONTH DAY YEAR NOV. 13 94		3. TIME OF DEATH HOURS MIN. P M 1:53 P M			
4. SOCIAL SECURITY NUMBER 220-80-2561		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 33 YRS.		7. DATE OF BIRTH MONTH DAY YEAR NOV. 8, 1961		8. BIRTHPLACE (State or Foreign) MARYLAND	
9a. FACILITY NAME (If not institution, give street and number) UNIVERSITY HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY			9c. COUNTY OF DEATH n/a		
10a. STATE MARYLAND		10b. COUNTY n/a		10c. CITY, TOWN OR LOCATION BALTIMORE			10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		
10e. STREET AND NUMBER 3224 BARCLAY STREET				10f. ZIP CODE 21218		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES			
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: BLACK		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 TH College (1-4 or 5+) -		18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DRIVER			16b. KIND OF BUSINESS/INDUSTRY INGRAM TRUCKING COMPANY				
17. FATHER'S NAME (First, Middle, Last) LEROY FRAZIER SR.				18. MOTHER'S NAME (First, Middle, Maiden Surname) ROCHELLE HODGES					
19a. INFORMANT'S NAME (Type/Print) LEROY FRAZIER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4021 WILSBY AVENUE, BALTIMORE, MARYLAND 21218					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) KING MM MEMORIAL PARK 11-18		20c. LOCATION — City or Town, State RANDALLSTOWN, MD					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE James Cook				22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH AVENUE					

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MULTIPLE INJURIES DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):				Approximate Interval Between Onset and Death					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 11/13/94		28b. TIME OF INJURY 12:58 PM		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED UNKNOWN	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) STREET				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 2900 BLK. FALLS RD. BALTO. MD.			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Mario F. Golle Jr.				29c. LICENSE NUMBER O.C.M.E		29d. DATE SIGNED (Month, Day, Year) NOV. 14, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mario F. Golle Jr. M.D. 111 Penn Street, Baltimore, Maryland 21201									
31. DATE FILED (Month, Day, Year) NOV 17 1994		32. REGISTRAR'S SIGNATURE Julia [Signature]							

BALTIMORE, MARYLAND 21215-0020

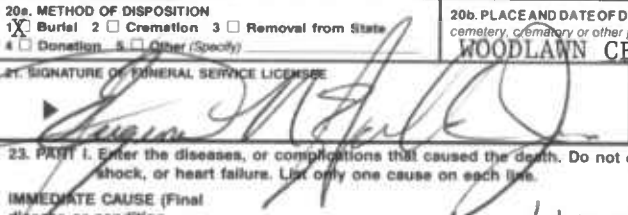
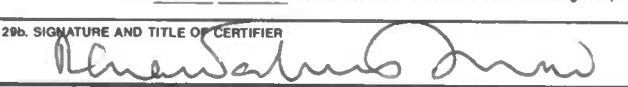
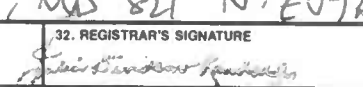
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33800

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ALICE R. FORBES				2. DATE OF DEATH MONTH 11 DAY 8 YEAR 94		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 217-24-9370		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 64 YRS.		7. DATE OF BIRTH (Month, Day, Year) 7/27/30	
8. BIRTHPLACE (State or Foreign Country) S.C.				9a. FACILITY NAME (If not institution, give street and number) 5520 WAYNE AVE.		9b. CITY, TOWN OR LOCATION OF DEATH BALTO.	
9c. COUNTY OF DEATH				10a. STATE MD			
10b. COUNTY				10c. CITY, TOWN OR LOCATION BALTO.			
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 5520 WAYNE AVE.			
10f. ZIP CODE 21207				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: AFR. AMERICAN	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) RETIRED		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) GEORGE ROBINSON				16. MOTHER'S NAME (First, Middle, Maiden Surname) VERA DUCKETT			
19a. INFORMANT'S NAME (Type/Print) WILLIAM FORBES				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5520 WAYNE AVE. BALTO. MD 21207			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) WOODLAWN CEM. 11/14/94		20c. LOCATION — City or Town, State BALTO. MD		22. NAME AND ADDRESS OF FACILITY ESTEP BROS. FUNERAL HOME P.A. 1300 EUTAW PLACE BALTO. MD 21217	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → LUNG CANCER Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): SARCOMA OF SMALL INTESTINE b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D29071		29d. DATE SIGNED (Month, Day, Year) 11.16.94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) R. KRISHNAN, MD 821 N. EUTAW ST #305 BALTIMORE MD 21201							
31. DATE FILED (Month, Day, Year) NOV 17 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.




TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33801

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) AMY FRANK			2. DATE OF DEATH MONTH DAY YEAR NOV. 14, 1994		3. TIME OF DEATH M 6:30 AM
4. SOCIAL SECURITY NUMBER 213-46-2647	5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 88 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 11/11/1906
9a. FACILITY NAME (If not institution, give street and number) 5415 GREENSPRING AVE.			9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH
RESIDENCE OF DECEDENT					
10a. STATE MARYLAND	10b. COUNTY		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
10e. STREET AND NUMBER 5415 GREENSPRING AVE.			10f. ZIP CODE 21209		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2		18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) housewife		16b. KIND OF BUSINESS/INDUSTRY at home	
17. FATHER'S NAME (First, Middle, Last) Max Heilbronner			18. MOTHER'S NAME (First, Middle, Maiden Surname) Stella Hirsch		
19a. INFORMANT'S NAME (Type/Print) Mrs. Marcia Allina			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5255 Sycamore ave Bronx NY 10471		
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HILLTOP SERVICE CORP. 11-15-94 TOWSON, MD		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTIMORE, MD 21215			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CEREBRAL HEMORRHAGE DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST					Approximate Interval Between Onset and Death 5 DAYS
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPD					24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER  D. SAPIR			29c. LICENSE NUMBER 010670		29d. DATE SIGNED (Month, Day, Year) 11/14/94
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) D. SAPIR GREEN SPRING STATION					
31. DATE FILED (Month, Day, Year) NOV 17 1994		32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33802

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ANNA M. FITZGERALD		2. DATE OF DEATH MONTH DAY YEAR NOV 13 1994		3. TIME OF DEATH 6:50 A M
4. SOCIAL SECURITY NUMBER 020-01-2367	5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 89 YRS.	7. DATE OF BIRTH (Month, Day, Year) FEB 12, 1905	8. BIRTHPLACE (State or Foreign Country) IRELAND
9a. FACILITY NAME (If not institution, give street and number) LORIEN NURSING HOME		9b. CITY, TOWN OR LOCATION OF DEATH COLUMBIA		9c. COUNTY OF DEATH HOWARD
RESIDENCE OF DECEDENT				
10a. STATE MD	10b. COUNTY HOWARD	10c. CITY, TOWN OR LOCATION COLUMBIA		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
10e. STREET AND NUMBER 6305 SETTING STAR		10f. ZIP CODE 21045	10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) NONE		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DOMESTIC WORKER		16b. KIND OF BUSINESS/INDUSTRY SOMEONE ELSE'S HOME
17. FATHER'S NAME (First, Middle, Last) MICHAEL LEAHY		18. MOTHER'S NAME (First, Middle, Maiden Surname) BRIDGET (UNKNOWN)		
19a. INFORMANT'S NAME (Type/Print) ROBERT PELLETIER (SON-IN-LAW)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6305 SETTING STAR, COLUMBIA, MD 21045		
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ST. MICHAEL'S CEM. NOV 17, 1994		20c. LOCATION — City or Town, State SPRINGFIELD, MASS.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY LEROY M & RUSSELL C WITZKE FUNERAL HOME 5555 TWIN KNOLLS RD. COLUMBIA, MD 21045		
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sepsis b. PNEUMONIA c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST				Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
		28d. DESCRIBE HOW INJURY OCCURRED		
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. SIGNATURE AND TITLE OF CERTIFIER Francis Bruno MD		29c. LICENSE NUMBER D09526	29d. DATE SIGNED (Month, Day, Year) Nov. 14, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FRANCIS BRUNO MD Med Arts Bldg, Columbia, MD 21045				
31. DATE FILED (Month, Day, Year) NOV 17 1994		32. REGISTRAR'S SIGNATURE 		

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) GARFIELD M. GRIFFIN, JR.				2. DATE OF DEATH MONTH 11 DAY 15 YEAR 94		3. TIME OF DEATH 12⁰⁰ A.M.	
4. SOCIAL SECURITY NUMBER 213-64-7035		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 38 YRS.		7. DATE OF BIRTH (Month, Day, Year) JAN. 4, 1956	
9a. FACILITY NAME (If not institution, give street and number) MERCY HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY			9c. COUNTY OF DEATH n/a		
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY n/a		10c. CITY, TOWN OR LOCATION BALTIMORE			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
10e. STREET AND NUMBER 1631 E. COLS COLDSRING				10f. ZIP CODE 21218		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 TH College (14 or 5+) -				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LABORER		16b. KIND OF BUSINESS/INDUSTRY BUREAU OF STORMSDRAIN CITY OF BALTIMORE	
17. FATHER'S NAME (First, Middle, Last) GARFIELD M. GRIFFITH SR.				18. MOTHER'S NAME (First, Middle, Maiden Surname) CARLENE M. RIVERS			
19a. INFORMANT'S NAME (Type/Print) GARFIELD M. GRIFFITH SR.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1631 E. COLDSRING LANE, BALTIMORE, MD 21218			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BALTIMORE CEMETERY 11-19		20c. LOCATION — City or Town, State BALTIMORE, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Glynis B. Scott</i>				22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH AVENUE			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Subarachnoid hemorrhage DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Cardiomyopathy/chronic active hepatitis C DUE TO (OR AS A CONSEQUENCE OF): c. Acquired Immunity Deficiency Syndrome DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. diabetes mellitus anemia							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD				29c. LICENSE NUMBER D02153		29d. DATE SIGNED (Month, Day, Year) 11/15/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. BUSSEY JONES MORRIS MEDICAL CTR BALTO MD 21302							
31. DATE FILED (Month, Day, Year) NOV 17 1994				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1998

94 33804

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) PATRICIA GROGAN GRADY				2. DATE OF DEATH MONTH DAY YEAR November 16, 1994		3. TIME OF DEATH 2:15A	
4. SOCIAL SECURITY NUMBER 212-05-1568		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 19, 1917	
9a. FACILITY NAME (If not institution, give street and number) 209 Goodale Road				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH N/A	
10a. STATE Maryland				10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 209 Goodale Road			
10f. ZIP CODE 21212				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Patrick Joseph Grogan				18. MOTHER'S NAME (First, Middle, Maiden Surname) Katherine A. Geraghty			
19a. INFORMANT'S NAME (Type/Print) J. Harold Grady				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 209 Goodale Road Baltimore, Maryland 21212			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) New Cathedral Cemetery 11/19		20c. LOCATION — City or Town, State Baltimore, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Harris H. H. H. H.</i>				22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home 650-0 York Road Baltimore, Maryland 21212			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cancer of the colon a. DUE TO (OR AS A CONSEQUENCE OF): METASTASIS TO THE LIVER b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST						Approximate Interval Between Onset and Death 1 Year	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Arteriosclerotic Cardiovascular Disease						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO						DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. PLACE OF DEATH (Check only one) OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Walter R. Welzant MD</i>		29c. LICENSE NUMBER D-12039		29d. DATE SIGNED (Month, Day, Year) November 17, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Walter R. Welzant 7600 Osler Drive Towson, Maryland 21204							
31. DATE FILED (Month, Day, Year) NOV 17 1994		32. REGISTRAR'S SIGNATURE <i>John A. Hudson</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33805

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) SARAH HANDLER				2. DATE OF DEATH MONTH 11 DAY 14 YEAR 94		3. TIME OF DEATH 17:21 M	
4. SOCIAL SECURITY NUMBER 220-05-2650		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 100 YRS.		7. DATE OF BIRTH (Month, Day, Year) 7/2/1894	
9a. FACILITY NAME (If not institution, give street and number) Harbor View Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT				10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10a. STATE MD		10b. COUNTY		10e. STREET AND NUMBER 1118 S. Scott Street		10f. ZIP CODE 21230	
10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: White		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		17. KIND OF BUSINESS/INDUSTRY At Home	
17. FATHER'S NAME (First, Middle, Last) Jake Curts				18. MOTHER'S NAME (First, Middle, Maiden Surname) Yetta Silverback			
19a. INFORMANT'S NAME (Type/Print) Paul Handler				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2552 Marlbourne Ave Balt. Md 21230			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Ohel Yaakov Cem		DATE 11-16-94		20c. LOCATION — City or Town, State Balt. Md	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Sydney L. Hillman</i>				22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. ACUTE MYOCARDIAL INFARCTION DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. CORONARY ARTERY DISEASE DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Varantra. Rai-P				29c. LICENSE NUMBER Home Staff		29d. DATE SIGNED (Month, Day, Year) 11/14/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. V. P. Rai Harbor Hospital Center							
31. DATE FILED (Month, Day, Year) NOV 17 1994		32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33806

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) James W. Harrell				2. DATE OF DEATH MONTH DAY YEAR November 15, 1994		3. TIME OF DEATH 12:20 P M	
4. SOCIAL SECURITY NUMBER 212-44-8219		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 49 YRS.		7. DATE OF BIRTH (Month, Day, Year) December 29, 1944	
9a. FACILITY NAME (If not institution, give street and number) 5873 Bellanca Drive				9b. CITY, TOWN OR LOCATION OF DEATH Elkridge		9c. COUNTY OF DEATH Howard	
RESIDENCE OF DECEDENT							
10a. STATE Md.		10b. COUNTY Howard		10c. CITY, TOWN OR LOCATION Elkridge		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 5873 Bellanca Drive				10f. ZIP CODE 21227		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Investigator		16b. KIND OF BUSINESS/INDUSTRY Public Defender			
17. FATHER'S NAME (First, Middle, Last) John W. Harrell				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Wright			
19a. INFORMANT'S NAME (Type/Print) Nora Jean Cooper				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5873 Bellanca Dr., Elkridge, Md. 21227			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) The Green Mount Cemetery 11/17		20c. LOCATION — City or Town, State Baltimore, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Gary L. Kaufman				22. NAME AND ADDRESS OF FACILITY Gary L. Kaufman Funeral Home of Elk., Inc. 5695 Main St., Elkridge, Md. 21227			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>H.I.V. INFECTION</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>ANEMIA</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>CHRONIC RETINOPATHY/ESOPHAGEAL</u> DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER James S. Sullivan Elkridge City MD				29c. LICENSE NUMBER MD 25210		29d. DATE SIGNED (Month, Day, Year) 11/16/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) NOV 17 1994				32. REGISTRAR'S SIGNATURE John A. Anderson			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

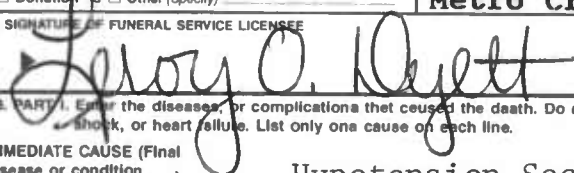

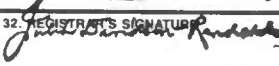
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

12-25-68 10:00 AM

94 33807

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Henry Herring				2. DATE OF DEATH MONTH DAY YEAR Nov. 16, 1994		3. TIME OF DEATH 2:51 A	
4. SOCIAL SECURITY NUMBER 249-62-9087		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		8. AGE (In yrs. last birthday) 55 YRS.		7. DATE OF BIRTH (Month, Day, Year) 6/6/1939	
9a. FACILITY NAME (If not institution, give street and number) Maryland General Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1517 N. BOND STREET				10f. ZIP CODE 21213		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Entrepreneur		16b. KIND OF BUSINESS/INDUSTRY Self-employed			
17. FATHER'S NAME (First, Middle, Last) George Herring				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mattie			
19a. INFORMANT'S NAME (Type/Print) Moses Wells				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1517 N. Bond Street Baltimore, MD 21213			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory 11/19		20c. LOCATION — City or Town, State Catonsville, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY LEROY O. DYETT & SON FUNERAL HOME 4600 LIBERTY HEIGHTS AVENUE 21207			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Hypotension Secondary to Sepsis Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Severe Peripheral Vascular Disease b. c. d. Approximate Interval Between Onset and Death: unknown						PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. PLACE OF DEATH (Check only one) OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER 89227		29d. DATE SIGNED (Month, Day, Year) 11/16/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Suhail Abbasi, M.D. c/o Maryland General Hospital							
31. DATE FILED NOV 17 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Cammie Belle Hughes</i>				2. DATE OF DEATH MONTH DAY YEAR <i>November 16, 1994</i>		3. TIME OF DEATH <i>10:30 A. M.</i>		
4. SOCIAL SECURITY NUMBER <i>227 22 6988</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>78</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>09/14/1916</i>		
9a. FACILITY NAME (If not institution, give street and number) <i>Harbor Hospital Center</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>		9c. COUNTY OF DEATH =====		
RESIDENCE OF DECEDENT								
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Baltimore County</i>		10c. CITY, TOWN OR LOCATION <i>Baltimore</i>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER <i>2763 Yannall Road</i>				10f. ZIP CODE <i>21227</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>7th</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Housewife</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Home Maker</i>				
17. FATHER'S NAME (First, Middle, Last) <i>Grover Hantless</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Cora Lee Tomlin</i>				
19a. INFORMANT'S NAME (Type/Print) <i>Walter Bowling Jr.</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2640 Virginia Avenue Baltimore, Maryland 21227</i>				
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Parkwood Cemetery 11/19</i>		20c. LOCATION — City or Town, State <i>Baltimore, Maryland</i>				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Richard C. Davis</i>				22. NAME AND ADDRESS OF FACILITY <i>George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225</i>				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Hypertensive Cardiovascular disease</i> DUE TO (OR AS A CONSEQUENCE OF):								
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								
DUE TO (OR AS A CONSEQUENCE OF):								
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURED				
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Seenuvasan MD</i>				29c. LICENSE NUMBER <i>D 17743</i>		29d. DATE SIGNED (Month, Day, Year) <i>11/17/94</i>		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>SEENUVASAN, MD, 606 Hammonds Lane, BALTO, Md, 21225.</i>								
31. DATE FILED (Month, Day, Year) <i>NOV 17 1994</i>		32. REGISTRAR'S SIGNATURE <i>Julia Hudson-Karall</i>						

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) EDWARD HARRIS				2. DATE OF DEATH MONTH DAY YEAR SEPT 27 1994		3. TIME OF DEATH 8:38 A.M.	
4. SOCIAL SECURITY NUMBER		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 57 YRS.		7. DATE OF BIRTH (Month, Day, Year) 6-7-37	
9a. FACILITY NAME (If not institution, give street and number) 2222 HENNEMAN AVENUE				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH na	
10a. STATE Maryland				10b. COUNTY na		10c. CITY, TOWN OR LOCATION Baltimore	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER 2222 Henneman Avenue				10f. ZIP CODE 21213		10g. CITIZEN OF WHAT COUNTRY?	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) ocme				18. MOTHER'S NAME (First, Middle, Maiden Surname)			
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ronald Wade, Dir</i>				22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655W. Baltimore St, Balto, MD 21201			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Arteriosclerotic Cardiovascular Disease</i> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetes Mellitus</i>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Laron Locke MD</i>				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) SEPT. 28, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. LARON LOCKE MD 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) NOV 17 1994				32. REGISTRAR'S SIGNATURE <i>Richard R. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Woodrow Jackson Sr.				2. DATE OF DEATH MONTH DAY YEAR November 14, 1994				3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 214-22-5596		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) November 18, 1919		8. BIRTHPLACE (State or Foreign Country) SC.	
9a. FACILITY NAME (If not institution, give street and number) Johns Hopkins Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore				9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT									
10a. STATE Md.		10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1808 N. Milton Avenue				10f. ZIP CODE 21213		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7th College (1-4 or 5 +)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Press Machine Operator		16b. KIND OF BUSINESS/INDUSTRY Iron Manufacturer			
17. FATHER'S NAME (First, Middle, Last) Sonny Williams				18. MOTHER'S NAME (First, Middle, Maiden Surname) Bessie Lila Johnson					
19a. INFORMANT'S NAME (Type/Print) Betty Scott				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6410 Lehnert Avenue Baltimore, Maryland 21207					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arbutus Memorial Park 11/19/94		20c. LOCATION — City or Town, State Arbutus, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Caple Funeral Service 5502 Winner Avenue Baltimore, Md. 21215					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Large Bowel Perforation DUE TO (OR AS A CONSEQUENCE OF): b. Disseminated Intravascular Coagulation DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death 1 day 1 day	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Prostate Cancer								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER Carlos S. Ince Jr. MD				29c. LICENSE NUMBER A04147357		29d. DATE SIGNED (Month, Day, Year) 11/16/94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Carlos S. Ince Jr. Johns Hopkins Hospital 600 N. Wolfe St. Balt. MD									
31. DATE FILED (Month, Day, Year) NOV 17 1994				32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33811

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <i>Helen T. Kearney</i>				2. DATE OF DEATH MONTH DAY YEAR <i>NOV 16, 94</i>		3. TIME OF DEATH <i>15:30 p.m.</i>	
4. SOCIAL SECURITY NUMBER <i>213-26-1027</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>66</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>July 17, 1928</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Northwest Hospital Center</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Randallstown</i>		9c. COUNTY OF DEATH <i>Baltimore</i>	
RESIDENCE OF DECEASED							
10a. STATE <i>Md.</i>		10b. COUNTY <i>Baltimore</i>		10c. CITY, TOWN OR LOCATION <i>Reisterstown</i>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>110 3rd Ave.</i>				10f. ZIP CODE <i>21136</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEASED'S EDUCATION (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i> <i>High School</i>				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Manager</i>		16b. KIND OF BUSINESS/INDUSTRY <i>HighsStore</i>	
17. FATHER'S NAME (First, Middle, Last) <i>John Goutos</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Caliope Mokris</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Mr. Francis X. Kearney</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>110 3rd Ave. Reisterstown, Md. 21136</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Garrison Forest Vet.Cem. 11/21/94</i>		20c. LOCATION — City or Town, State <i>Owings Mills, Md.</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Eline B. Eline</i>				22. NAME AND ADDRESS OF FACILITY <i>11824 Reisterstown Rd. Eline Funeral Home Reisterstown, Md. 21136</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>End stage of Emphysema</i> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide <input type="checkbox"/> Other		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Alice H. Smith</i>				29c. LICENSE NUMBER <i>H43974</i>		29d. DATE SIGNED (Month, Day, Year) <i>NOV 16, 94</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>NW Hospital Randallstown Md</i>							
31. DATE FILED (Month, Day, Year) <i>NOV 17 1994</i>				32. REGISTRAR'S SIGNATURE <i>John B. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33812

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LEONARD STANFORD KAGAN				2. DATE OF DEATH NOV. 11, 1994 YEAR		3. TIME OF DEATH 4:17 am M	
4. SOCIAL SECURITY NUMBER 103-36-0891		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 51 YRS.		7. DATE OF BIRTH (Month, Day, Year) MAR. 30, 1943	
8. BIRTHPLACE (State or Foreign Country) NEW YORK		9. FACILITY NAME (If not institution, give street and number) 59 RAISIN TREE CIRCLE		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH BALTIMORE	
10a. STATE MARYLAND		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 59 RAISIN TREE CIRCLE		10f. ZIP CODE 21208		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+) 5+		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ARCHITECT		16b. KIND OF BUSINESS/INDUSTRY BUILDING			
17. FATHER'S NAME (First, Middle, Last) HENRY KAGAN				18. MOTHER'S NAME (First, Middle, Maiden Surname) BELLA LIPSCHITZ			
19a. INFORMANT'S NAME (Type/Print) MRS. ANN KAGAN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 59 RAISIN TREE CIRCLE BALTIMORE, MD 21208			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of place) DRUID RIDGE — 11-14-94 PIKESVILLE, MD		20c. LOCATION — City or Town, State		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Renal Failure Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Diabetes mellitus (insulin dependent) c. Coronary artery disease d. Coronary artery disease							Approximate Interval Between Onset and Death Yrs
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary artery disease							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER 018914		29d. DATE SIGNED (Month, Day, Year) 11/11/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 2328 W. Joppa Rd. Lutherville Md 21093							
31. DATE FILED (Month, Day, Year) NOV 17 1994				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Madeline Julia KABERNAGEL				2. DATE OF DEATH MONTH DAY YEAR November 14, 1994		3. TIME OF DEATH 6:30 am. M	
4. SOCIAL SECURITY NUMBER 212-09-7388		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) 07/20/1920	
8. BIRTHPLACE (State or Foreign Country) Canada				9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Rossville	
9c. COUNTY OF DEATH Baltimore				10a. STATE Maryland		10b. COUNTY Baltimore	
10c. CITY, TOWN OR LOCATION Dundalk				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 6607 Marne Avenue	
10f. ZIP CODE 21224				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 8 Years				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Waitress		16b. KIND OF BUSINESS/INDUSTRY Minnicks Restaurant	
17. FATHER'S NAME (First, Middle, Last) Frank Wojtkowiak				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Buczynski			
19a. INFORMANT'S NAME (Type/Print) Francis B. Kabernagel				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 407 Bowleys Quarters Road Baltimore, MD 21220			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Oak Lawn Cemetery 11/17/94		20c. LOCATION — City or Town, State Baltimore, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, MD 21222			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiogenic Shock							
DUE TO (OR AS A CONSEQUENCE OF):							
b. Acute Anterior Myocardial infarction							
DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Liji Mathew				29c. LICENSE NUMBER RD1779		29d. DATE SIGNED (Month, Day, Year) 11/17/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Liji Mathew, M.D. 9000 Franklin Square Drive Baltimore, MD 21237							
31. DATE FILED (Month, Day, Year) NOV 17 1994				32. REGISTRAR'S SIGNATURE Julia Shuckan-Rodell			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Margaret Kraft Virginia Kraft				2. DATE OF DEATH MONTH 11 DAY 14 YEAR 94		3. TIME OF DEATH 2:30 A M	
4. SOCIAL SECURITY NUMBER 215-44-1336		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 81 YRS.		7. DATE OF BIRTH (Month, Day, Year) 08/21/1913	
9a. FACILITY NAME (If not institution, give street and number) Harford Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Havre de Grace		9c. COUNTY OF DEATH Harford	
10a. STATE Maryland				10b. COUNTY Harford		10c. CITY, TOWN OR LOCATION Havre de Grace	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 415 South Market Street			
10f. ZIP CODE 21078				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Unknown		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		17. KIND OF BUSINESS/INDUSTRY Domestic			
17. FATHER'S NAME (First, Middle, Last) John Schlisler				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah Rebecca Mule			
19a. INFORMANT'S NAME (Type/Print) Patricia A. Chassereau				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 511 Walkers Way Bel Air, Maryland 21015			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Holly Hill Mem. Pk. 11/16/94		20c. LOCATION — City or Town, State Middle River, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cerebral Vascular Accident. a. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER 246412		29d. DATE SIGNED (Month, Day, Year) 11/14/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 701 Union Ave Havre de Grace MD 21078							
31. DATE FILED (Month, Day, Year) NOV 17 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33815

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) BRUCE KUTCHEY				2. DATE OF DEATH MONTH DAY YEAR NOVEMBER 11, 1994		3. TIME OF DEATH 08:20 P M		
4. SOCIAL SECURITY NUMBER 212-48-1709A		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 46 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10-17-48		
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		
9c. COUNTY OF DEATH				10a. STATE MARYLAND				
10b. COUNTY HARFORD		10c. CITY, TOWN OR LOCATION		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 104 WHEEL COURT		
10f. ZIP CODE 21015		10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (14 or 5+) <input checked="" type="checkbox"/> 3 YRS.		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LONG SHOREMAN		
16b. KIND OF BUSINESS/INDUSTRY STA2ILA		17. FATHER'S NAME (First, Middle, Last) BERNARD KUTCHEY		18. MOTHER'S NAME (First, Middle, Maiden Surname) ELLEN HARRIMAN				
19a. INFORMANT'S NAME (Type/Print) MR. MARK KUTCHEY		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6731 BESSEMER AVENUE BALTO., MD. 21222						
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GREEN MOUNT CEM.		DATE 11-14		20c. LOCATION — City or Town, State BALTO., MD. 2122		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>		22. NAME AND ADDRESS OF FACILITY KACZOROWSKI FUNERAL HOME 1201 DUNDALK AVENUE BALTO., MD. 21222						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sepsis Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. Immunosuppression b. c. d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic rejection Heart Transplantation.							Approximate Interval Between Onset and Death 4 days 2 yrs.	
24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Nomicide <input type="checkbox"/>		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> RESIDENT		29c. LICENSE NUMBER 1883 (ST. ANNES HOSPITAL)		29d. DATE SIGNED (Month, Day, Year) 11/11/94		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOHNS HOPKINS HOSPITAL BALTIMORE, MD								
31. DATE FILED (Month, Day, Year) NOV 17 1994		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>						

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HENRY KATZSCO				2. DATE OF DEATH MONTH 11 DAY 14 YEAR 94		3. TIME OF DEATH 2:55 PM	
4. SOCIAL SECURITY NUMBER 212.12.2475		5. SEX 1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 71 73 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 7 1921	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9. COUNTY OF DEATH A.A. COUNTY			
9a. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL ASSOCIATION				9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE		9c. COUNTY OF DEATH A.A. COUNTY	
10a. STATE MARYLAND		10b. COUNTY ANNE ARUNDEL		10c. CITY, TOWN OR LOCATION GLEN BURNIE		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 207 MARIE AVENUE				10f. ZIP CODE 21060		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1944-1946		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) NONE				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LUMBER SALES MANAGER		16b. KIND OF BUSINESS/INDUSTRY JOHNSON LUMBER COMPANY	
17. FATHER'S NAME (First, Middle, Last) UNKNOWN				18. MOTHER'S NAME (First, Middle, Maiden Surname) NASTASIA (UNKNOWN)			
19a. INFORMANT'S NAME (Type/Print) JESSIE A. KATZSCO				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 207 MARIE AVENUE GLEN BURNIE, MARYLAND 21060			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HILLTOP SERVICE CORP. 11-16 TOWSON, MARYLAND		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME 1 SECOND AVE. S.W. GLEN BURNIE, MD 21061			
23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sepsis and hypoglycemia DUE TO (OR AS A CONSEQUENCE OF): a. Arterial occlusion - 9 left leg DUE TO (OR AS A CONSEQUENCE OF): b. Severe peripheral vascular disease DUE TO (OR AS A CONSEQUENCE OF): c. Severe atherosclerosis and hypertension DUE TO (OR AS A CONSEQUENCE OF): d. years Approximate Interval Between Onset and Death days Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. thoracic & abdominal aortic aneurysms Chronic diabetes							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, term, street, factory, office, building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED					
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Bayinnah Shabazz M.D.				29c. LICENSE NUMBER D24592		29d. DATE SIGNED (Month, Day, Year) 11-14-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BAYINNAH SHABAZZ, M.D./1600 CRAIN HIGHWAY SW/GLEN BURNIE, MARYLAND 21061							
31. DATE FILED (Month, Day, Year) NOV 17 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33817

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) William Eugene Kram				2. DATE OF DEATH MONTH DAY YEAR November 9, 1994		3. TIME OF DEATH 2:00 A M	
4. SOCIAL SECURITY NUMBER 212-42-6041		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 54 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 19, 1940	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) 2227 McHenry St.		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH				10a. STATE Md.		10b. COUNTY	
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 2227 McHenry St.	
10f. ZIP CODE 21223				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR OATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 6				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Never Worked		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) James J. Kram, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Cecelia S. Dubiel			
19a. INFORMANT'S NAME (Type/Print) Cecelia S. Kram				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2227 McHenry St., Balto., Md. 21223			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Meadowridge Memorial Park 11/14		20c. LOCATION — City or Town, State Elkridge, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gary L. Kaufman</i>				22. NAME AND ADDRESS OF FACILITY Gary L. Kaufman Funeral Home of Elk., Inc. 5695 Main St., Elkridge, Md. 21227			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>metastatic colon cancer</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>lymphoma</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death a. <i>6 months</i> b. <i>3 months</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Other (Specify)				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — A1 home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John Ottaviano MD</i>				29c. LICENSE NUMBER D40850		29d. DATE SIGNED (Month, Day, Year) 11/11/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) YVONNE OTTAVIANO 900 CATON AVE BALTIMORE MD 21229							
31. DATE FILED (Month, Day, Year) NOV 17 1994				32. REGISTRAR'S SIGNATURE <i>John D. Anderson-Rudack</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33818

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ARCHIE C. KERNS, JR				2. DATE OF DEATH MONTH 11 DAY 16 YEAR 94		3. TIME OF DEATH 12:10 A.M.	
4. SOCIAL SECURITY NUMBER 219 28 3918		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 58 YRS.		7. DATE OF BIRTH (Month, Day, Year) 12-07-35	
9a. FACILITY NAME (If not institution, give street and number) JOHNS HOPKINS GEN. CTN.				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH Maryland	
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Essex		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 18 Wagner Lane				10f. ZIP CODE 21221		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES Korean		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Machine Operator		16b. KIND OF BUSINESS/INDUSTRY Food Processing			
17. FATHER'S NAME (First, Middle, Last) Archie C. Kerns				18. MOTHER'S NAME (First, Middle, Maiden Surname) Helen Kenzer			
19a. INFORMANT'S NAME (Type/Print) Katheryn F. Kerns				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 116 Seneca Rd. Baltimore, MD 21220			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Holly Hill Memorial Gardens 11/18/94 Baltimore Co., MD		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Bruzdinski Funeral Home PA 1407 Eastern Ave. Balto., MD 21221			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SEPSIS DUE TO (OR AS A CONSEQUENCE OF): b. METASTATIC CARCINOMA (Colon) DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death days
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. (RIGHT ARM ABSCESS, COPD)							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER DO 4383		29d. DATE SIGNED (Month, Day, Year) 11/16/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) William B. Greenough III MD 5505 Hopkins Blvd. BALTO MD 21224							
31. DATE FILED (Month, Day, Year) NOV 17 1994				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33819

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Edward Keen				2. DATE OF DEATH 11-9-94		3. TIME OF DEATH 6:54 AM	
4. SOCIAL SECURITY NUMBER 434 14 4808		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) 12-3-1914	
9a. FACILITY NAME (If not Institution, give street and number) Laurel Regional Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Laurel		9c. COUNTY OF DEATH Prince Geo Co	
10a. STATE Maryland				10b. COUNTY Prince Geo Co		10c. CITY, TOWN OR LOCATION Laurel	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER Golden Oaks Nurs Hm 9001 Cherry Lane			
10f. ZIP CODE 20707				10g. CITIZEN OF WHAT COUNTRY?			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)			
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, Dir				22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655W. Baltimore St, Balto, MD 21201			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pneumonia DUE TO (OR AS A CONSEQUENCE OF): Adult Respiratory Distress Syndrome DUE TO (OR AS A CONSEQUENCE OF): Gastrointestinal Bleed DUE TO (OR AS A CONSEQUENCE OF): Gangrene of Small Bowel Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death 2 weeks
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal Failure							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Dr. Taylor MD				29c. LICENSE NUMBER D25430		29d. DATE SIGNED (Month, Day, Year) 11/9/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John MARGOLIS, 14333 Lgwd Boue RD #307 Laurel MD 20708							
31. DATE FILED (Month, Day, Year) NOV 17 1994				32. REGISTRAR'S SIGNATURE Amirah Radell			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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94 33820

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ROBERT B. LEWIS				2. DATE OF DEATH MONTH 11 DAY 7 YEAR 94		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 237-20-1840		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		7. DATE OF BIRTH (Month, Day, Year) 4/1/1922	
9a. FACILITY NAME (If not institution, give street and number) UNION MEM. HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTO.		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE MD		10b. COUNTY		10c. CITY, TOWN OR LOCATION BALTO.		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 2313 AISQUITH ST.				10f. ZIP CODE 21218		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: AFR. AMERICAN	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) RETIRED		16b. KIND OF BUSINESS/INDUSTRY UNKNOWN			
17. FATHER'S NAME (First, Middle, Last) ARCHIE LEWIS				18. MOTHER'S NAME (First, Middle, Maiden Surname) PENNY LEWIS			
19a. INFORMANT'S NAME (Type/Print) JUANITA LEWIS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2313 AISQUITH ST. BALTO. MD 21218			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT. ZION CEM. 11/12/94		20c. LOCATION — City or Town, State BALTO. MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PLACE BALTO. MD 21217			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): b. Hypertensive Cardiovascular disease DUE TO (OR AS A CONSEQUENCE OF): c. Arteriosclerotic Cardiovascular disease DUE TO (OR AS A CONSEQUENCE OF): d. Apical Myocardial Infarction (remote) Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death 2 months many years many years years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetic Nephropathy Cigarette Smoking DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER F.C. Caguin, M.D.				29c. LICENSE NUMBER D01372		29d. DATE SIGNED (Month, Day, Year) 11/16/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 230 E. 25th Street Baltimore, MD 21218							
31. DATE FILED (Month, Day, Year) NOV 17 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33821

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) LEO LOWERY				2. DATE OF DEATH MONTH 11 DAY 15 YEAR 1994		3. TIME OF DEATH 12:00 P M	
4. SOCIAL SECURITY NUMBER 217-18-6087		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 69 YRS.	7. DATE OF BIRTH (Month, Day, Year) May 5, 1925		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) Good Samaritan Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH -	
10a. STATE Maryland				10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Essex	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 1213 Elsing Rd.				10f. ZIP CODE 21221		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) -		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Long Shoreman		16b. KIND OF BUSINESS/INDUSTRY Shipping			
17. FATHER'S NAME (First, Middle, Last) Walter C. Lowery				18. MOTHER'S NAME (First, Middle, Maiden Surname) Pauline Freeburger			
19a. INFORMANT'S NAME (Type/Print) Cynthia Massari				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1700 Loft Way Silver Spring, MD 20904			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Stanislaus Cemetery 11/18/94		20c. LOCATION — City or Town, State Baltimore, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Bruzdzinski Funeral Home PA 1407 Eastern Ave. Baltimore, MD 21221			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. VENTRICULAR FIBRILLATION DUE TO (OR AS A CONSEQUENCE OF): b. SEVERE BIVENTRICULAR FAILURE DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ISCHEMIC CARDIOMYOPATHY CAD, CHRONIC A-FIB.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>		29c. LICENSE NUMBER A-06711		29d. DATE SIGNED (Month, Day, Year) 11/15/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) Anna Marie U Brown Good Samaritan Hosp							
31. DATE FILED (Month, Day, Year) NOV 17 1994		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.
1. DECEDENT'S NAME (First, Middle, Last) DAMEON MARCELL LANE						2. DATE OF DEATH MONTH NOV DAY 11 YEAR 1994		3. TIME OF DEATH 20 39 P M		
4. SOCIAL SECURITY NUMBER 215-86-1321		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 24 YRS.	7. DATE OF BIRTH (Month, Day, Year) 5-12-1970		8. BIRTHPLACE (State or Foreign Country) Md				
9a. FACILITY NAME (If not institution, give street and number) 1200 Poplar Grove Street						9b. CITY, TOWN OR LOCATION OF DEATH BALTO		9c. COUNTY OF DEATH		
10a. STATE Md		10b. COUNTY		10c. CITY, TOWN OR LOCATION Balto		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				
10e. STREET AND NUMBER 42 Wyndmoor Place				10f. ZIP CODE 21207		10g. CITIZEN OF WHAT COUNTRY? U S A				
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		15b. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) unknown		16b. KIND OF BUSINESS/INDUSTRY						
17. FATHER'S NAME (First, Middle, Last) Cliburn Lane, Jr				18. MOTHER'S NAME (First, Middle, Maiden Surname) Beverly Lunn						
19a. INFORMANT'S NAME (Type/Print) Beverly Douglas				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 42 Wyndmoor Place Apt F Balto, Md 21207						
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arbutus Memorial Park		DATE		20c. LOCATION — City or Town, State Arbutus, Md				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Sola March</i>				22. NAME AND ADDRESS OF FACILITY March F/H West 4300 Wabash Avenue Balto, Md 21215						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple gunshot wounds DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death		
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) ON STREET								
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input checked="" type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 11/11/94		28b. TIME OF INJURY 2030 M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED SUBJECT SHOT		
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Street (in auto)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 1200 Poplar Grove St. Balto. MD		29c. LICENSE NUMBER OCME		29d. DATE SIGNED (Month, Day, Year) NOV. 12, 1994		
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Donald G. Wright MD</i> Deputy Chief		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Donald G. Wright M.D. 111 Penn Street, Baltimore, Maryland 21201								
31. DATE SIGNED (Month, Day, Year) NOV 17 1994		32. REGISTRAR'S SIGNATURE <i>John Sander</i>								

94 33823

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ETHEL MOSLEY				2. DATE OF DEATH MONTH 11 DAY 14 YEAR 94		3. TIME OF DEATH 11 10 AM	
4. SOCIAL SECURITY NUMBER 247-26-5738		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) 8-20-20	
8. FACILITY NAME (If not institution, give street and number) St. Agnes Hospital				9. CITY, TOWN OR LOCATION OF DEATH Baltimore		10. COUNTY OF DEATH S.C.	
10a. STATE MD		10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 2901 Walbrook Ave				10f. ZIP CODE 21216		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Home Maker		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) Willie Darby				18. MOTHER'S NAME (First, Middle, Maiden Surname) Eliza Darby			
19a. INFORMANT'S NAME (Type/Print) Gwendolyn Mack				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 921 Lynhurst St. Balt. MD 21229			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of place, City or Town, State, Zip Code) Western Star Cem 11-18-94 Balt. MD		20c. LOCATION — City or Town, State Balt. MD		20d. DATE 11-18-94	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Estep Bros. Funeral Home 7300 Eutaw Place Balt. MD 21217			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sepsis Due to (or as a consequence of): b. Pneumonia Due to (or as a consequence of): c. COPD Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death 4 day 7 day 10 year
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Resident		29c. LICENSE NUMBER D76292		29d. DATE SIGNED (Month, Day, Year) 11/15/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JUAN Mer Keli 900 Caron Av. Balt. MD 21229							
31. DATE FILED (Month, Day, Year) NOV 17 1994		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33824

ITEMS: 1. & 19a, PER F.H. FILM G-717 11/17/94 t.t

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) AMANDA J. JANE MILLMAN				2. DATE OF DEATH MONTH DAY YEAR Nov. 13, 1994		3. TIME OF DEATH 2003 PM	
4. SOCIAL SECURITY NUMBER 234 - 22 - 9827		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) Mar 27, 1917	
8. BIRTHPLACE (State or Foreign Country) West Virginia				9a. FACILITY NAME (If not institution, give street and number) Washington Adventist Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Takoma Park	
9c. COUNTY OF DEATH Montgomery				10a. STATE Maryland		10b. COUNTY Prince George	
10c. CITY, TOWN OR LOCATION Laurel				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 13014 Laurel-Bowie Road #301	
10f. ZIP CODE 20708				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Grade 11 College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY Own Home	
17. FATHER'S NAME (First, Middle, Last) James Llewlyn Thomasson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah Frances Brabbin			
19a. INFORMANT'S NAME (Type/Print) HARRY J. MILLMAN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7918 Chapel Cove Drive, Laurel, Maryland 20707			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arlington Cemetery Co. 11/16 Drexel Hill, PA		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. HEART FAILURE DUE TO (OR AS A CONSEQUENCE OF): b. SEVERE VALVULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): c. SEVERE AORTIC DISEASE DUE TO (OR AS A CONSEQUENCE OF): d. SEVERE MITRAL REGURGITATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. RENAL FAILURE MULTIPLE SYSTEM FAILURE- VALVE REPLACEMENT - PECTUS EXCAVATUM DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <input type="checkbox"/> M <input type="checkbox"/> P <input type="checkbox"/> NO	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER 18551		29d. DATE SIGNED (Month, Day, Year) Nov. 13, 94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SAMIR NEIMAT, M.D. 7610 CARROLL AV. TAKOMA PARK, MD, 20912							
31. DATE FILED (Month, Day, Year) NOV 17 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33825

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) THEODORE E. MARTIN JR.				2. DATE OF DEATH MONTH 11 DAY 15 YEAR 94		3. TIME OF DEATH 11:30 A. M.	
4. SOCIAL SECURITY NUMBER 215-07-8098		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 76 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec. 12, 1917	
9a. FACILITY NAME (If not institution, give street and number) St. Agnes Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH Maryland	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Catonsville		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 6106 Regent Park Road				10f. ZIP CODE 21228		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W W II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 1+ College (1-4 or 5+) 1+		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Insurance Broker		15b. KIND OF BUSINESS/INDUSTRY Insurance			
17. FATHER'S NAME (First, Middle, Last) Theodore E. Martin Sr.				16. MOTHER'S NAME (First, Middle, Maiden Surname) Evelyn Read			
19a. INFORMANT'S NAME (Type/Print) Margaret D. Martin (Spouse)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6106 Regent Park Road Catonsville Maryland 21228			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Loudon Park Cemetery 11-18-94		DATE 11-18-94		20c. LOCATION — City or Town, State Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>B. Gray Witzke</i>				22. NAME AND ADDRESS OF FACILITY Leroy M & Russell C Witzke Funeral Homes 1630 Edmondson Avenue Catonsville Maryland			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
e. SEPSIS DUE TO (OR AS A CONSEQUENCE OF):							
b. PROSTATIC ABSCESS DUE TO (OR AS A CONSEQUENCE OF):							
c. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
Coronary Atherosclerosis, Marked							
Myocardial Infarction, Old							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. DATE OF INJURY			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Michael E. Pelczar</i>				29c. LICENSE NUMBER D09990		29d. DATE SIGNED (Month, Day, Year) 11/15/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Michael E. Pelczar, St. Agnes Hospital, 900 Caton Ave., Baltimore, Md. 21229							
31. DATE FILED (Month, Day, Year) NOV 17 1994				32. REGISTRAR'S SIGNATURE <i>John S. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

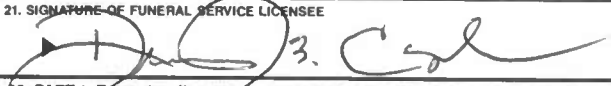
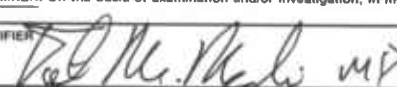
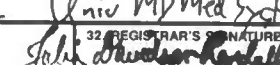
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33826

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Shirley Ann Gaither McQueen				2. DATE OF DEATH MONTH DAY YEAR November 14, 1994				3. TIME OF DEATH 3:50 am M			
4. SOCIAL SECURITY NUMBER 219-80-9207		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 36 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7. DATE OF BIRTH (Month, Day, Year) May 18, 1958				8. BIRTHPLACE (State or Foreign Country) Maryland							
9a. FACILITY NAME (If not institution, give street and number) Seton Manor Nursing Center				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore				9c. COUNTY OF DEATH			
RESIDENCE OF DECEDENT											
10a. STATE Md.		10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 709 Edgewood Street				10f. ZIP CODE 21229		10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (13-16) 5+				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Assembly Clerk		16b. KIND OF BUSINESS/INDUSTRY Floor Tile Manufacturing					
17. FATHER'S NAME (First, Middle, Last) James Gaither				18. MOTHER'S NAME (First, Middle, Maiden Surname) Fannie B. Kelly							
19a. INFORMANT'S NAME (Type/Print) Fannie B. Gaither				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 709 Edgewood Street Baltimore, Maryland 21229							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) King Memorial Park 11/18/94		20c. LOCATION — City or Town, State Randallstown, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Caple Funeral Service 5502 Winner Avenue Baltimore, Md. 21215							
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Pulmonary Hemorrhage</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Pneumonia</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>Mycobacterium Avium Infection</u> DUE TO (OR AS A CONSEQUENCE OF): d. <u>HIV Infection</u> Approximate interval between Onset and Death minutes 2 days ~ 6 months ~ 4 yrs								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Anemia</u>											
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER  MD		29c. LICENSE NUMBER D38637		29d. DATE SIGNED (Month, Day, Year) 11/16/94					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. David Margolis, Univ MD Med Sch, 29 S. Greene St, Baltimore MD 21201											
31. DATE FILED (Month, Day, Year) NOV 17 1994		32. REGISTRAR'S SIGNATURE 									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33827

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Evelyn Carol McDermott				2. DATE OF DEATH MONTH DAY YEAR November 16, 1994		3. TIME OF DEATH M M	
4. SOCIAL SECURITY NUMBER 216 32 4727		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 58 YRS.		7. DATE OF BIRTH (Month, Day, Year) 11/28/1935	
9a. FACILITY NAME (If not institution, give street and number) Bay Meadows Nursing Center				9b. CITY, TOWN OR LOCATION OF DEATH Glen Burnie		9c. COUNTY OF DEATH Anne Arundel	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 4409 Fenor Road				10f. ZIP CODE 21227		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. DO NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY Secretarial			
17. FATHER'S NAME (First, Middle, Last) Harry Snyder				18. MOTHER'S NAME (First, Middle, Maiden Surname) Evelyn Ritter			
19a. INFORMANT'S NAME (Type/Print) Deborah Littlejohn				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4409 Fenor Road Baltimore, Maryland 21227			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Loudon Park Cemetery 11/17		20c. LOCATION — City or Town, State Baltimore, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>C. Richard Gonce</i>				22. NAME AND ADDRESS OF FACILITY George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic Ca pancreas a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> M.D.				29c. LICENSE NUMBER D27569		29d. DATE SIGNED (Month, Day, Year) 11/16/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Allen Goffelman 1777 Reisterstown Rd #365							
31. FILED (Month, Day, Year) NOV 17 1994 <i>[Signature]</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MORRIS P MARSTON				2. DATE OF DEATH MONTH DAY YEAR NOVEMBER-11-94		3. TIME OF DEATH 10:40 A M	
4. SOCIAL SECURITY NUMBER 212-03-9960		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 82 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) JULY 3, 1912	
9a. FACILITY NAME (If not institution, give street and number) NORTHWEST HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH RANDALLSTOWN		9c. COUNTY OF DEATH BALTIMORE	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 725 MT WILSON LANE, APT. 419				10f. ZIP CODE 21208		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CERTIFIED PUBLIC ACCOUNTANT —ACCOUNTING		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) JACOB MARMELSTEIN				18. MOTHER'S NAME (First, Middle, Maiden Surname) KATE ZAX			
19a. INFORMANT'S NAME (Type/Print) MRS. Belle MARSTON				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 725 MT. WILSON LANE, APT. 419 BALTIMORE, MD 21208			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MOSES MONTEFIORE		DATE 11-14-94		20c. LOCATION — City or Town, State BALTIMORE, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jay Alan Levin</i>				22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): ASPIRATION PNEUMONIA b. DUE TO (OR AS A CONSEQUENCE OF): PARKINSONS DISEASE c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death one day 8 days > 1 yr.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Afroze Munee MD				29c. LICENSE NUMBER D45105		29d. DATE SIGNED (Month, Day, Year) 11/11/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) AFROZE MUNEER. 5401 OLD COURT ROAD. RANDALLSTOWN MD 21133							
31. DATE FILED (Month, Day, Year) NOV 17 1994		32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

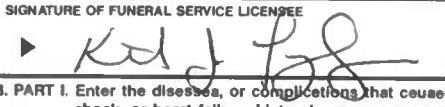

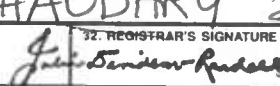
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33829

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Gustave Julius Munki Jr.				2. DATE OF DEATH MONTH DAY YEAR November 13 1994		3. TIME OF DEATH 1230 a M	
4. SOCIAL SECURITY NUMBER 220-30-4805		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 61 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 29 1933	
8. BIRTHPLACE (State or Foreign Country) Baltimore Md.				9a. FACILITY NAME (If not institution, give street and number) 2112 Suburban Greens Dr.		9b. CITY, TOWN OR LOCATION OF DEATH Timonium Md.	
10a. STATE Md.				10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Timonium	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 2112 Suburban Greens DR.			
10f. ZIP CODE 21093				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES Korean		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Material Expiditer		16b. KIND OF BUSINESS/INDUSTRY Steel Mill	
17. FATHER'S NAME (First, Middle, Last) Gustave Julius Munki Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Amelia unknown Pencek			
19a. INFORMANT'S NAME (Type/Print) Margaret Munki				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2112 Suburban Greens Dr. Timonium Md. 21093			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Cemetery 11-16-94		20c. LOCATION — City or Town, State Timonium Md.		20d. DATE 11-16-94	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY 21204 Ruck Towson F.H. 1050 York Rd. Towson Md.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic carcinoma of the prostate Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D41406		29d. DATE SIGNED (Month, Day, Year) 11/14/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MADHU CHAUDHRY 22 South Greene St Baltimore MD 21201							
31. DATE FILED (Month, Day, Year) NOV 17 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LEON E. MOORE, SR.				2. DATE OF DEATH MONTH DAY YEAR NOV. 14 94		3. TIME OF DEATH 10:29P M	
4. SOCIAL SECURITY NUMBER 219 52 9488		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 44 YRS.		7. DATE OF BIRTH (Month, Day, Year) DEC 18, 1949	
8. BIRTHPLACE (State or Foreign Country) MARYLAND		9a. FACILITY NAME (If not institution, give street and number) ST. AGNES		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 743 YALE AVENUE				10f. ZIP CODE 21229		10g. CITIZEN OF WHAT COUNTRY? U. S. OF A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Vietnam 11/12/69		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— if yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH College (1-4 or 5+) CUSTODIAN		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CUSTODIAN		15b. KIND OF BUSINESS/INDUSTRY U.S. POST OFFICE			
17. FATHER'S NAME (First, Middle, Last) JESSIE EDWARD MOORE				16. MOTHER'S NAME (First, Middle, Maiden Surname) HELEN HAGUE			
19a. INFORMANT'S NAME (Type/Print) MRS. LINDA Y. MOORE				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 743 YALE AVENUE BALTIMORE, MARYLAND 21229			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of place, city or town, or cemetery) ARBUTUS MEM. PK. 11/19/94		20c. LOCATION — City or Town, State BALTIMORE, MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Lewis T. Gwynn</i>		22. NAME AND ADDRESS OF FACILITY LEWIS T. GWYNN FUNERAL HOME 21215 45187 PARK HEIGHTS AVE. BALTO., MD.					
23. PART I. Enter the diseases, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Atherosclerosis Cardiovascular disease							
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Inspection				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. PLACE OF DEATH (Check only one) OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 11-14-94		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John D. Fowler</i>				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) NOV. 15/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David R Fowler 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) NOV 17 1994		32. REGISTRAR'S SIGNATURE <i>John D. Fowler</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33831

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JOSEPH FRANCIS McADAM IV				2. DATE OF DEATH MONTH DAY YEAR NOV. 14, 1994		3. TIME OF DEATH 10:20 P M	
4. SOCIAL SECURITY NUMBER 217-48-0757		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 37 YRS.		7. DATE OF BIRTH (Month, Day, Year) OCT. 1, 1957	
8a. FACILITY NAME (If not institution, give street and number) 1319 GLENDALE ROAD				8b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		8c. COUNTY OF DEATH BALTIMORE	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 1319 GLENDALE ROAD				10f. ZIP CODE 21239		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SYSTEMS NETWORK ENG.		16b. KIND OF BUSINESS/INDUSTRY BANKING			
17. FATHER'S NAME (First, Middle, Last) JOSEPH FRANCIS McADAM III				18. MOTHER'S NAME (First, Middle, Maiden Surname) NORMA RAGONESE			
19a. INFORMANT'S NAME (Type/Print) MARINA K. McADAM				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1319 GLENDALE ROAD BALTIMORE, MD. 21239			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HILLTOP SERVICE CORP. 11/18/94		20c. LOCATION — City or Town, State TOWSON, MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John E. Dolan</i> JOHN E. DOLAN				22. NAME AND ADDRESS OF FACILITY RUCK TOWSON FUNERAL HOME INC 1050 YORK ROAD TOWSON, MD. 21204			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>malignant melanoma</i> DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Paul Celano</i>				29c. LICENSE NUMBER 2905-29		29d. DATE SIGNED (Month, Day, Year) 11/15/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. PAUL CELANO 6569 N. CHARLES STREET SUITE 205W BALTIMORE, MD.							
31. DATE FILED (Month, Day, Year) NOV 17 1994				32. REGISTRAR'S SIGNATURE <i>John Benison-Rubell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33832

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Boss, Moore				2. DATE OF DEATH MONTH 11 DAY 8 YEAR 94				3. TIME OF DEATH 9:55 PM					
4. SOCIAL SECURITY NUMBER 423 12 5095				5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 63 YRS.		7. DATE OF BIRTH (Month, Day, Year) 4-10-1921		8. BIRTHPLACE (State or Foreign Country)			
9a. FACILITY NAME (If not institution, give street and number) Mercy Medical Center						9b. CITY, TOWN OR LOCATION OF DEATH Baltimore			9c. COUNTY OF DEATH na				
RESIDENCE OF DECEDENT													
10a. STATE Maryland				10b. COUNTY na				10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 124 W. Franklin Street						10f. ZIP CODE 21202			10g. CITIZEN OF WHAT COUNTRY?				
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>						16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last)						18. MOTHER'S NAME (First, Middle, Maiden Surname)							
19a. INFORMANT'S NAME (Type/Print)						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify): in state removal						20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)				20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ronald Wade, Dir</i>						22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655W. Baltimore St, Balto, MD 21201							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Chronic Obstructive Pulmonary Disease DUE TO (OR AS A CONSEQUENCE OF):													
b. DUE TO (OR AS A CONSEQUENCE OF):													
c. DUE TO (OR AS A CONSEQUENCE OF):													
d. DUE TO (OR AS A CONSEQUENCE OF):													
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined						28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED						28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)							
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)													
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Aaron R. Turz</i>						29c. LICENSE NUMBER P08178			29d. DATE SIGNED (Month, Day, Year) 11/8/94				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Aaron R. Turz, 301 St. Paul Place Balto, MD 21202													
31. DATE FILED (Month, Day, Year) NOV 17 1994						32. REGISTRAR'S SIGNATURE <i>Michael R. Hall</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33833

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MILDRED CLAIRE MC AULAY				2. DATE OF DEATH MONTH 11 DAY 2 YEAR 94		3. TIME OF DEATH 5:07P M	
4. SOCIAL SECURITY NUMBER 539 12 7966		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) 3-12-1911	
9a. FACILITY NAME (If not institution, give street and number) 23605 Woodfield Road				9b. CITY, TOWN OR LOCATION OF DEATH Damascus		9c. COUNTY OF DEATH Montgomery Co	
10a. STATE Maryland				10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Damascus	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 23605 Woodfield Road			
10f. ZIP CODE 20872				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES no		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12+ College (1-4 or 5+) Teacher		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Teacher		16b. KIND OF BUSINESS/INDUSTRY Education			
17. FATHER'S NAME (First, Middle, Last) Howard R. Bankerd				18. MOTHER'S NAME (First, Middle, Maiden Surname) Maybelle Claire Raub			
19a. INFORMANT'S NAME (Type/Print) Jean Mc Aulay				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12459 Route # 216, Highland, MD 20777			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DATE		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, Dir				22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655W. Baltimore St, Balto, MD 21201			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF): Emphysema DUE TO (OR AS A CONSEQUENCE OF): Chronic Bronchitis DUE TO (OR AS A CONSEQUENCE OF): ASTHMA Approximate Interval Between Onset and Death 6 mo 20 yrs 20 yrs 40 yrs							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Probable Carcinoma of the Lung							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER Dr. Stewart Scott				29c. LICENSE NUMBER D05727		29d. DATE SIGNED (Month, Day, Year) 11/7/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR STEWART SCOTT 19201 Montgomery Village Ave #A12, Gaithersburg, MD							
31. DATE FILED (Month, Day, Year) NOV 17 1994				32. REGISTRAR'S SIGNATURE Asst. Registrar			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33834

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Louis Henry NIEBRUGGE				2. DATE OF DEATH MONTH DAY YEAR November 14, 1994		3. TIME OF DEATH 7:15 P M	
4. SOCIAL SECURITY NUMBER 515-10-5076		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 80 YRS.		7. DATE OF BIRTH (Month, Day, Year) January 7, 1914	
8. BIRTHPLACE (State or Foreign Country) Illinois				9. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital		10. CITY, TOWN OR LOCATION OF DEATH Baltimore	
11. RESIDENCE OF DECEDENT				12. STATE Fl.		13. COUNTY Lee	
14. CITY, TOWN OR LOCATION N. Fort Myers				15. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		16. STREET AND NUMBER 41 Winter Rest Way	
17. ZIP CODE 33903				18. CITIZEN OF WHAT COUNTRY? USA		19. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
20. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES				21. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		22. RACE — American Indian, Black, White, etc. Specify: white	
23. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) 7				24. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Relief Worker		25. KIND OF BUSINESS/INDUSTRY Brewery Industry	
26. FATHER'S NAME (First, Middle, Last) Frank Niebrugge				27. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Zwinger			
28. INFORMANT'S NAME (Type/Print) Richard Remas				29. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 428 Torner Rd., Baltimore, Md. 21221			
30. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				31. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) The Green Mount Cemetery 11/		32. LOCATION — City or Town, State Baltimore, Md.	
33. SIGNATURE OF FUNERAL SERVICE LICENSEE 				34. NAME AND ADDRESS OF FACILITY Gary L. Kaufman Funeral Home of Elk., Inc. 5695 Main St., Elkridge, Md. 21227			
35. PART I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → s. <u>PULMONARY EMBOLISM</u> b. <u>MULTIPLE ORGAN DISEASE</u> c. <u></u> d. <u></u> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
36. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u></u>							
37. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>				38. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		39. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
40. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				41. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
42. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined				43. DATE OF INJURY (Month, Day, Year) 28a. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		44. DESCRIBE HOW INJURY OCCURRED 28d. DESCRIBE HOW INJURY OCCURRED	
45. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28e. PLACE OF INJURY				46. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28f. LOCATION			
47. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
48. SIGNATURE AND TITLE OF CERTIFIER 				49. LICENSE NUMBER AF 232-8412-1757		50. DATE SIGNED (Month, Day, Year) 11/14/94	
51. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ROBERT DE LA TORRE, M.D. 9000 FRANKLIN SQUARE DRIVE							
52. DATE FILED (Month, Day, Year) NOV 17 1994				53. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33835

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Robert G. Nevelus				2. DATE OF DEATH MONTH DAY YEAR November 14, 1994		3. TIME OF DEATH 7:30 P M	
4. SOCIAL SECURITY NUMBER 130-30-8427		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 54 YRS.		7. DATE OF BIRTH (Month, Day, Year) May 30, 1940	
9a. FACILITY NAME (If not institution, give street and number) 4803 Frederick Ave.				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH	
10a. STATE Md.				10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 4803 Frederick Ave.		10f. ZIP CODE 21229	
10g. CITIZEN OF WHAT COUNTRY? USA				11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: white			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Manufacturer's Rep.		16b. KIND OF BUSINESS/INDUSTRY Sales	
17. FATHER'S NAME (First, Middle, Last) Matthew E. Nevelus				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary J. Papp			
19a. INFORMANT'S NAME (Type/Print) Janet L. Nevelus				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4803 Frederick Ave., Balto., Md. 21229			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Loudon Park Cemetery 11/17		20c. LOCATION — City or Town, State Baltimore, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gary L. Kaufman</i>				22. NAME AND ADDRESS OF FACILITY Gary L. Kaufman Funeral Home of Elk., Inc. 5695 Main St., Elkridge, Md. 21227			
23. PART I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Lymphoma Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death 7 mos
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)					
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER D23887		29d. DATE SIGNED (Month/Day/Year) 11/15/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Richard Ambinder 418 N. Bond St Johns Hopkins Oncology							
31. DATE FILED (Month, Day, Year) NOV 17 1994				32. REGISTRAR'S SIGNATURE <i>Julia Benson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33836

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Lucille Elizabeth Naumann</i>			2. DATE OF DEATH MONTH DAY YEAR <i>November 16, 1994</i>		3. TIME OF DEATH A. M. P. <i>5:50 A.</i>
4. SOCIAL SECURITY NUMBER <i>219 16 5108</i>	5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <i>69</i> YRS.	7. DATE OF BIRTH (Month, Day, Year) <i>12/22/1924</i>	8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Meridian Nursing Center</i>			9b. CITY, TOWN OR LOCATION OF DEATH <i>Severna Park</i>		9c. COUNTY OF DEATH <i>Anne Arundel</i>
RESIDENCE OF DECEDENT					
10a. STATE <i>Maryland</i>	10b. COUNTY <i>Anne Arundel</i>	10c. CITY, TOWN OR LOCATION <i>Baltimore</i>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>5616 Harbor Valley Drive</i>		10f. ZIP CODE <i>21225</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify	
14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>8th</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Waitress</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Hotel</i>	
17. FATHER'S NAME (First, Middle, Last) <i>Vincent Lee Williams Sr.</i>			18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Flora Elizabeth Langlotz</i>		
19a. INFORMANT'S NAME (Type/Print) <i>Gloria Joseph</i>			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>5616 Harbor Valley Drive Baltimore, Maryland 21225</i>		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Lorraine Park Cemetery 11/19</i>		20c. LOCATION — City or Town, State <i>Baltimore, Maryland</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donna M. Zmurski</i>		22. NAME AND ADDRESS OF FACILITY <i>George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Lymphoma</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.					Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>ARTERIOCLEROTIC CARDIOVASCULAR DISEASE</i>					24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Attending</i>		29c. LICENSE NUMBER <i>D 21776</i>	29d. DATE SIGNED (Month, Day, Year) <i>11/16/94</i>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>SURYA P. MUNDRA MD 203 E PATAPSCO AV BALT. MD 21225</i>					
31. DATE FILED (Month, Day, Year) <i>NOV 17 1994</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33837

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Marie Neu Feld				2. DATE OF DEATH MONTH 11 DAY 13 YEAR 1994		3. TIME OF DEATH 12:17 P.M.	
4. SOCIAL SECURITY NUMBER		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 79 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) OCT. 10, 1915	
8. BIRTHPLACE (State or Foreign Country) POLAND				9a. FACILITY NAME (If not institution, give street and number) LEVINDALE		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE	
10a. STATE MARYLAND				10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION BALTIMORE	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 6023 HIGHGATE DRIVE		10f. ZIP CODE 21215	
10g. CITIZEN OF WHAT COUNTRY? USA				11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) SEAMSTRESS	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CLOTHING				16b. KIND OF BUSINESS/INDUSTRY CLOTHING		17. FATHER'S NAME (First, Middle, Last) SHIMON MITL GROM	
18. MOTHER'S NAME (First, Middle, Maiden Surname) HENYA ROSENCZWEIG				19a. INFORMANT'S NAME (Type/Print) MRS. HELENE SIEGEL		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 HAMLET HILL, APT. 811 BALTIMORE, MD 21210	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place) BETH TFILOH		20c. LOCATION — City or Town, State 11-14-1994 BALTIMORE, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Scott M. Cutler				22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTIMORE, MD 21215		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Respiratory Failure Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST pneumonia sepsis	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined	
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER M. J.		29c. LICENSE NUMBER 544817	
29d. DATE SIGNED (Month, Day, Year) 11-14-94				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SUNIL P. RAJANI Levindale Hospital, Baltimore, MD 21215		31. DATE FILED (Month, Day, Year) NOV 17 1994	
32. REGISTRAR'S SIGNATURE John Davidson-Randall							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33838

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Charles S. Powell</i>				2. DATE OF DEATH MONTH <i>11</i> DAY <i>13</i> YEAR <i>94</i>		3. TIME OF DEATH <i>5:00 P M</i>	
4. SOCIAL SECURITY NUMBER <i>216-24-9354</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>65</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>1-22-30</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>VETERANS HOSPITAL GREEN STREET</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>BALTIMORE</i>		9c. COUNTY OF DEATH <i>MARYLAND</i>	
RESIDENCE OF DECEDENT							
10a. STATE <i>MARYLAND</i>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <i>BALTIMORE</i>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>2525 FOSTER AVENUE</i>				10f. ZIP CODE <i>21224</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>KOREA</i>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>WHITE</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>7 YEARS</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>MECHANIST</i>		16b. KIND OF BUSINESS/INDUSTRY <i>NATIONAL WIRE PRODUCTS</i>			
17. FATHER'S NAME (First, Middle, Last) <i>BENJAMIN G. POWELL</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>MARIE SHERMAN</i>			
19a. INFORMANT'S NAME (Type/Print) <i>MRS. SHARON FORWARD</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>409 STONEGATE BLVD. BALTO. MD. 21921</i>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>GREEN MOUNT CEM</i>		20c. LOCATION — City or Town, State <i>11-17 BALTO. MD.</i>		20d. DATE <i>11-17</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Charles S. Kaczorowski</i>				22. NAME AND ADDRESS OF FACILITY <i>KACZOROWSKI FUNERAL HOME 2525 FLEET ST. BALTO., MD. 21224</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. intracranial mass lesion</i> DUE TO (OR AS A CONSEQUENCE OF): <i>b. MYOCARDIAL INFARCTION</i> DUE TO (OR AS A CONSEQUENCE OF): <i>c. multiple myeloma</i> DUE TO (OR AS A CONSEQUENCE OF): <i>d. pneumonia</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>renal failure, urinary tract inf.</i>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jan-M. Klapproth M.D.</i>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <i>11-13-94</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Jan-M. Klapproth, VA Med. Ctr., 10 S. Greene Sts., 21201 Baltimore</i>							
31. DATE FILED (Month, Day, Year) <i>NOV 17 1994</i>				32. REGISTRAR'S SIGNATURE <i>John Benner</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33839

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JAMES WILSON PICKETT				2. DATE OF DEATH MONTH DAY YEAR NOVEMBER 13, 1994		3. TIME OF DEATH 12:01 A M	
4. SOCIAL SECURITY NUMBER 219-28-4014		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 60 YRS.		7. DATE OF BIRTH (Month, Day, Year) JUNE 10, 1934	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) ST. AGNES HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE	
9c. COUNTY OF DEATH				10a. STATE MARYLAND			
10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION HALETHORPE		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 4419 MAPLE AVENUE	
10f. ZIP CODE 21227		10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) C.P.A.	
16b. KIND OF BUSINESS/INDUSTRY INSURANCE		17. FATHER'S NAME (First, Middle, Last) BENJAMIN FRANKLIN PICKETT		18. MOTHER'S NAME (First, Middle, Maiden Surname) ELSIE MAY PADGETT		19a. INFORMANT'S NAME (Type/Print) RITA S. PICKETT (WIFE)	
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4419 MAPLE AVENUE HALETHORPE MARYLAND 21227		20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of 11-16-94 DATE Meadowridge MARYLAND VETERANS CEMETERY		20c. LOCATION — City or Town, State Dorsey CARRISON FOREST, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Leroy M. Witzke</i>		22. NAME AND ADDRESS OF FACILITY LEROY M & RUSSELL C WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE CATONSVILLE MARYLAND		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Coronary Artery Disease (Ventricular fibrillation) DUE TO (OR AS A CONSEQUENCE OF): Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Possible Contribution by myocardial infarction in the field DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	
28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Stephen J. Plantholt MD</i>		29c. LICENSE NUMBER	
29d. DATE SIGNED (Month, Day, Year) 11/13/94		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) STEPHEN J. PLANTHOLT MD, 3449 WILKENS AVE, BALTO, 21229		31. DATE FILED (Month, Day, Year) NOV 17 1994		32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>	

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The attending physician must sign this certificate after death. Hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate is completed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

94 33840

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Corinthia Pennington				2. DATE OF DEATH MONTH November DAY 9 YEAR 1994		3. TIME OF DEATH 09:40 A.M.	
4. SOCIAL SECURITY NUMBER		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 59 YRS.	7. DATE OF BIRTH (Month, Day, Year) 6-11-35	8. BIRTHPLACE (State or Foreign Country) MD		
9a. FACILITY NAME (If not institution, give street and number) Sinai Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH	
10a. STATE MD		10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 4032 McDowell Lane				10f. ZIP CODE 21227		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Blk	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Retired		16b. KIND OF BUSINESS/INDUSTRY UNKNOWN			
17. FATHER'S NAME (First, Middle, Last) JAMES R. PENNINGTON SR.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Vivian A. Pennington			
19a. INFORMANT'S NAME (Type/Print) Saburah A. Rahman 'bey				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 Hummingbird Ct. Balt. MD 21227			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of facility, cemetery or other place) Metropolitan Cemetery 11-15-94		20c. LOCATION — City or Town, State Catonville MD		22. NAME AND ADDRESS OF FACILITY Estep Bros. Funeral Home P.A. 1300 Eutaw Place Balt. MD 21217	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sepsis DUE TO (OR AS A CONSEQUENCE OF): Empyema DUE TO (OR AS A CONSEQUENCE OF): Pneumothorax DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 1 day 1 day 1 day			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Decubitus ulcers, Coronary Artery Disease, Atrial Fibrillation Left hemiplegia; bilateral Above Knee amputations				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER John A. Lippert, M.D.				29c. LICENSE NUMBER AS2404321-JL9836		29d. DATE SIGNED (Month, Day, Year) November 9, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John A. Lippert, M.D. Sinai Hospital							
31. DATE FILED (Month, Day, Year) NOV 17 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

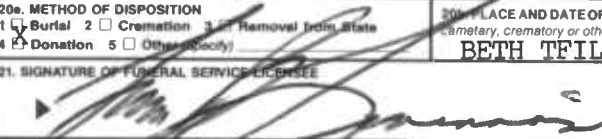
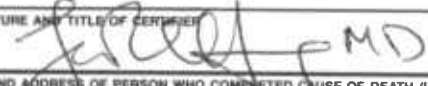
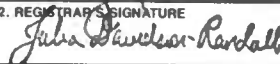
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) BERNARD Joseph POLEY				2. DATE OF DEATH MONTH DAY YEAR NOVEMBER 15, 1994		3. TIME OF DEATH 11:58 a.m.	
4. SOCIAL SECURITY NUMBER 122-24-9449		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 62 YRS.		7. DATE OF BIRTH (Month, Day, Year) DEC. 3, 1931	
8. BIRTHPLACE (State or Foreign Country) NEW YORK				9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY	
9c. COUNTY OF DEATH				10a. STATE MD		10b. COUNTY BALTIMORE	
10c. CITY, TOWN OR LOCATION BALTIMORE				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 9 BRICKFORD LANE	
10f. ZIP CODE 21208				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES KOREA-NAVY				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) PRESIDENT		16b. KIND OF BUSINESS/INDUSTRY Stair STAIR BUILDERS	
17. FATHER'S NAME (First, Middle, Last) ABRAHAM POLEY				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARGARET NEY			
19a. INFORMANT'S NAME (Type/Print) MRS. CHARLENE POLEY				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 BRICKFORD LANE, BALTIMORE, MD 21208			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BETH TFILOH		20c. LOCATION — City or Town, State 11-16-94 BALTIMORE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. Hyperammonemia DUE TO (OR AS A CONSEQUENCE OF): b. Renal failure DUE TO (OR AS A CONSEQUENCE OF): c. Gastric Varices DUE TO (OR AS A CONSEQUENCE OF): d. Lymphoma							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  MD				29c. LICENSE NUMBER D5880		29d. DATE SIGNED (Month, Day, Year) 4/15/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Leon Huang, Johns Hopkins Oncology							
31. DATE FILED (Month, Day, Year) NOV 17 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33842

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) YETTA PEARLMAN				2. DATE OF DEATH MONTH DAY YEAR NOV. 13, 1994		3. TIME OF DEATH 8:35 PM		
4. SOCIAL SECURITY NUMBER 129-10-6713		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) OCT. 31, 1917		8. BIRTHPLACE (State or Foreign Country) NEW YORK	
9a. FACILITY NAME (If not institution, give street and number) SINAI HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH		
10a. STATE MARYLAND		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 8282 VOSGES ROAD				10f. ZIP CODE 21244		10g. CITIZEN OF WHAT COUNTRY? USA		
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) BOOKKEEPER		16b. KIND OF BUSINESS/INDUSTRY REAL ESTATE				
17. FATHER'S NAME (First, Middle, Last) HARRY HOUSMAN				18. MOTHER'S NAME (First, Middle, Maiden Surname) GUSSIE				
19a. INFORMANT'S NAME (Type/Print) MRS. ROBIN SCHULMAN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9221 QUICK FOX COLUMBIA, MD 21045				
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of place or other place) MIKRO KODESH BETH ISRAEL 11-16-94 BALTIMORE, MD		20c. LOCATION — City or Town, State				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 Reisterstown RD. BALTIMORE, MD 21215				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MASSIVE INTRACEREBRAL HEMORRHAGE DUE TO (OR AS A CONSEQUENCE OF): b. HYPERTENSION DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. SIGNATURE AND TITLE OF CERTIFIER Rama Shankar RAMASHANKAR				29c. LICENSE NUMBER AS24 02321RS9736		29d. DATE SIGNED (Month, Day, Year) 11-13-94		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RAMA SHANKAR SINAI HOSP OF BALTIMORE								
31. DATE FILED (Month, Day, Year) 11-13-94 NOV 17 1994				32. REGISTRAR'S SIGNATURE 				

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Veruan
Ricketts
death - 8:25 am 11/15/94

94 33843

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) Vivian Evelyn Ricketts				2. DATE OF DEATH MONTH DAY YEAR Nov. 15, 1994		3. TIME OF DEATH 8:25 a m			
4. SOCIAL SECURITY NUMBER 212-14-5217		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 8, 1920		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) Laurel Regional Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Laurel			9c. COUNTY OF DEATH Prince George		
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Burtonsville			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 4011 Sandy Spring Road				10f. ZIP CODE 20866		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: white		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (14 or 5+) 6				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife			16b. KIND OF BUSINESS/INDUSTRY Home		
17. FATHER'S NAME (First, Middle, Last) Blair Thomas				18. MOTHER'S NAME (First, Middle, Maiden Surname) Nellie May Howard					
19a. INFORMANT'S NAME (Type/Print) Janice Pattison				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1149 12th Street Laurel, Maryland 20707					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Union Cemetery		DATE 11/18		20c. LOCATION — City or Town, State Burtonsville, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gregory S. K...</i>				22. NAME AND ADDRESS OF FACILITY Donaldson Funeral Home P.A. 313 Talbott Avenue Laurel, Maryland 20707					

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>lymphomatous meningitis</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>malignant lymphoma</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST				Approximate interval Between Onset and Death									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Martin D. Wertz MD</i>				29c. LICENSE NUMBER D25743		29d. DATE SIGNED (Month, Day, Year) 11/15/94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Greenbelt, MD, MARTIN D. WERTZ - 2070</i>													
31. DATE FILED (Month, Day, Year) NOV 17 1994				32. REGISTRAR'S SIGNATURE <i>John S. ...</i>									

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) Ida Mae Richardson				2. DATE OF DEATH MONTH 11 DAY 10 YEAR 1994		3. TIME OF DEATH M					
4. SOCIAL SECURITY NUMBER 212-36-1666		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		7. DATE OF BIRTH (Month, Day, Year) 6/27/22		8. BIRTHPLACE (State or Foreign Country) N.C.			
9a. FACILITY NAME (If not institution, give street and number) 7876 Quarterfield Road				9b. CITY, TOWN OR LOCATION OF DEATH Severn			9c. COUNTY OF DEATH				
RESIDENCE OF DECEASED				10a. STATE Md		10b. COUNTY		10c. CITY, TOWN OR LOCATION Severn			
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 7876 Quarterfield Road		10f. ZIP CODE 21144		10g. CITIZEN OF WHAT COUNTRY? U S A			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No) If yes, specify Cuban, Mexican, Puerto Rican, etc. 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black					
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th		15a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Maid		16b. KIND OF BUSINESS/INDUSTRY Lord Balto Hotel							
17. FATHER'S NAME (First, Middle, Last) John Richardson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Fannie High							
19a. INFORMANT'S NAME (Type/Print) Fannie Sumter				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7876 Quarterfield Road Severn, Md 21144							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) Meadow Ridge Cemetery		DATE 11/14/94		20c. LOCATION — City or Town, State Elkridge, Md					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Sola March</i>				22. NAME AND ADDRESS OF FACILITY March F/H West 4300 Wabash Avenue Balto, Md 21215							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequitentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <i>UPPER</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>CERVICAL CANCER</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>E. J. [Signature]</i>						29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 11/14/94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) L. M. [Signature] BALTO, MD											
31. DATE FILED (Month, Day, Year) NOV 17 1994				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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94 33845

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) STANLEY RESNICK			2. DATE OF DEATH MONTH NOVEMBER DAY 15 YEAR 1994			3. TIME OF DEATH 12:25 p. M				
4. SOCIAL SECURITY NUMBER		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 64 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan. 18, 1930		8. BIRTHPLACE (State or Foreign Country) Baltimore, MD		
9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY			9c. COUNTY OF DEATH			
10a. STATE MD			10b. COUNTY			10c. CITY, TOWN OR LOCATION Baltimore			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 6701 Park Heights Avenue, Apt. 3B						10f. ZIP CODE 21215		10g. CITIZEN OF WHAT COUNTRY? usa		
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES Korea		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: white			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4 or 5+) 5			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Certified Public Accountant			16b. KIND OF BUSINESS/INDUSTRY Accounting				
17. FATHER'S NAME (First, Middle, Last) Louis Resnick						18. MOTHER'S NAME (First, Middle, Maiden Surname) Lillian Bliss				
19a. INFORMANT'S NAME (Type/Print) Mrs. Marlene Resnick						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6701 Park Hgts. Ave; APT. 3B; Baltimore, MD 21215				
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Moses Montefiore 11-16-94			20c. LOCATION — City or Town, State Baltimore, MD				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 						22. NAME AND ADDRESS OF FACILITY Sol Levinson & Bros, Inc. 6010 Reisterstown Rd; Balto, MD 21215				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pulmonary embolus DUE TO (OR AS A CONSEQUENCE OF): a. Bilateral femoral venous thromboses DUE TO (OR AS A CONSEQUENCE OF): b. Hypercoagulable state DUE TO (OR AS A CONSEQUENCE OF): c. Hepatocellular carcinoma Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary artery disease									Approximate Interval Between Onset and Death 5 minutes 1 week 1 year 1 year	
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>										
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined			28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. SIGNATURE AND TITLE OF CERTIFIER M.D. Medical Housestaff							
29c. LICENSE NUMBER M0282			29d. DATE SIGNED (Month, Day, Year) 11/15/94							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Katherine Wu, M.D., 600 N. Wolfe St, JHH, Baltimore, MD 21205										
31. DATE FILED (Month, Day, Year) NOV 17 1994			32. REGISTRAR'S SIGNATURE 							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.



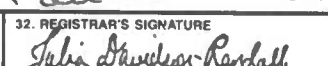
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33846

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ANNette Rosenbluth				2. DATE OF DEATH MONTH NOV DAY 13 YEAR 94		3. TIME OF DEATH 1:45 PM	
4. SOCIAL SECURITY NUMBER 217-24-1875		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 66 YRS.		7. DATE OF BIRTH (Month, Day, Year) JAN 29, 1928	
9a. FACILITY NAME (If not institution, give street and number) MONTGOMERY GENERAL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH ROCKVILLE		9c. COUNTY OF DEATH MONTGOMERY	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY MONTGOMERY		10c. CITY, TOWN OR LOCATION ROCKVILLE		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 14514 HOMECREST RD.				10f. ZIP CODE 20906		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) SECRETARY		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SECRETARY		16b. KIND OF BUSINESS/INDUSTRY INVESTMENT			
17. FATHER'S NAME (First, Middle, Last) MORRIS COHEN				18. MOTHER'S NAME (First, Middle, Maiden Surname) EVA WEINSTEIN			
19a. INFORMANT'S NAME (Type/Print) MR. STEVEN ROSENBLUTH				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1334 ORCHARD WAY FREDERICK, MD 21702			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place) PETACH TIKVAH 11-15-94 ROSEDALE, MD		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC 6010 REISTERSTOWN RD BALTIMORE, MD 21215			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Subdural hematoma DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				28. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) OCT 30 94		28b. TIME OF INJURY — M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED Fall at home		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Home		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 14514 Homecrest Rd			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER 208546		29d. DATE SIGNED (Month, Day, Year) NOV 13 94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John Tamber 8218 Wisconsin Ave Bethesda							
31. DATE FILED (Month, Day, Year) NOV 17 1994				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) SOPHIA F. RICHMOND				2. DATE OF DEATH MONTH 11 - DAY 12 - YEAR 94		3. TIME OF DEATH 3:40 P M			
4. SOCIAL SECURITY NUMBER 213-48-7238		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 90 YRS.		7. DATE OF BIRTH (Month, Day, Year) 8/18/04		8. BIRTHPLACE (State or Foreign Country) MARYLAND	
9a. FACILITY NAME (If not institution, give street and number) MERIDIAN BRIGHTWOOD NURSING HOME				9b. CITY, TOWN OR LOCATION OF DEATH BROOKLANDVILLE			9c. COUNTY OF DEATH BALTIMORE		
RESIDENCE OF DECEASED									
10a. STATE MARYLAND		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION BAL TIMORE			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 3405 RETLAW RD.				10f. ZIP CODE 21208 21207		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: WHITE		
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 1				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE			16b. KIND OF BUSINESS/INDUSTRY HOMEMAKER		
17. FATHER'S NAME (First, Middle, Last) JACOB EDWARD FORMAN				18. MOTHER'S NAME (First, Middle, Maiden Surname) ROSE BERMAN					
19a. INFORMANT'S NAME (Type/Print) MRS. ELAINE LEVY				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7203 ROCKLAND HILLS DR. APT. 206 BALTO, MD(21209)					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HEBREW FRIENDSHIP CEM. 11/14		20c. LOCATION — City or Town, State BALTIMORE, MD.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Sylvia J. Stillman</i>				22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS. 6010 REISTERSTOWN RD. BALTO., MD. (21215)					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardiopulmonary Arrest</i> a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO									
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Deer is Ude</i>		29c. LICENSE NUMBER 041614		29d. DATE SIGNED (Month, Day, Year) 11-13-94			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Alan Halle 4000 Old Ct Rd Balt 21208									
31. DATE FILED (Month, Day, Year) NOV 17 1994			32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>						

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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94 33848

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Marie Rybarczyk				2. DATE OF DEATH MONTH DAY YEAR November 14 1994		3. TIME OF DEATH 12:40 PM	
4. SOCIAL SECURITY NUMBER 215-14-9205		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) August 21, 1911	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Hamilton Nursing Center		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH				10a. STATE Maryland		10b. COUNTY Baltimore	
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 4709 Woodlea Avenue	
10f. ZIP CODE 21206				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) Ignatius Dobrochowski				18. MOTHER'S NAME (First, Middle, Maiden Surname)			
19a. INFORMANT'S NAME (Type/Print) Mr. Edward Rybarczyk				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8507 Bassett Road Baltimore, Md. 21206			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hilltop Service Corporation 11/16/94		20c. LOCATION — City or Town, State Towson, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Mark T. Zavovna				22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, 21214			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Myocardial infarction/CHF DUE TO (OR AS A CONSEQUENCE OF): b. Atherosclerosis DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Malnutrition Atrial fibrillation							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]	
29c. LICENSE NUMBER D22419				29d. DATE SIGNED (Month, Day, Year) 11/15/94		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Patricia M. Disharoon, M.D. 3414 St. Paul Street Baltimore, Maryland	
31. DATE FILED (Month, Day, Year) NOV 17 1994				32. REGISTRAR'S SIGNATURE [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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94 33849

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Lucinda Simon</i>				2. DATE OF DEATH MONTH <i>11</i> - DAY <i>7</i> - YEAR <i>94</i>		3. TIME OF DEATH <i>3:55 PM</i>	
4. SOCIAL SECURITY NUMBER <i>214-62-8380</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>40</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Aug. 16, 1954</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Univ. of MD Hosp.</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>BALTO.</i>		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE <i>MD</i>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <i>BALTO.</i>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>4528 Northwood Ave</i>				10f. ZIP CODE <i>21239</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>BIK</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>College</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>RETAIL SALES</i>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <i>Willie J. Simon SR.</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>KENA HAMPLETON</i>			
19a. INFORMANT'S NAME (Type/Print) <i>KENA HAMPLETON</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>4528 Northwood Ave BALTO. MD 21239</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place) <i>BA ZION Cem 11-12-94</i>		20c. LOCATION — City or Town, State <i>BALTO. MD</i>		22. NAME AND ADDRESS OF FACILITY <i>ESTER BROS. FUNERAL Hm. 1300 EUTAW PLACE BALTO. MD</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Aspiration pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF): <i>AIDS</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <i>AIDS</i> b. <i>AIDS</i> c. <i>AIDS</i> d. <i>AIDS</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Matthew Frank MD</i>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <i>11/04/94</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Matthew Frank MD Univ. of MD Hospital</i>							
31. DATE FILED (Month, Day, Year) <i>NOV 17 1994</i>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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94 33850

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LAURA ETHEL STEVENS				2. DATE OF DEATH MONTH 11 DAY 14 YEAR 94		3. TIME OF DEATH 10:33 AM	
4. SOCIAL SECURITY NUMBER 199-20-6742		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 12, 1917	
9a. FACILITY NAME (If not institution, give street and number) St. Agnes Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Catonsville		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 410 Roanoke Drive				10f. ZIP CODE 21228		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		15b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Raymond Cain				18. MOTHER'S NAME (First, Middle, Maiden Surname) Bess Lowe			
19a. INFORMANT'S NAME (Type/Print) Thomas D. Stevens (Spouse)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 410 Roanoke Drive Catonsville, Maryland 21228			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory 11-15-94		20c. LOCATION — City or Town, State Catonsville, Maryland		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Leroy M & Russell C Witzke Funeral Homes 1630 Edmondson Avenue Catonsville Maryland			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF):				Approximate Interval Between Onset and Death	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		b. Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Pulmonary Disease							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Stephen J. Plantz MD				29c. LICENSE NUMBER D23580		29d. DATE SIGNED (Month, Day, Year) 11/14/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Stephen J. Plantz 3449 WILKENS AVE BALTO MD 21229							
31. DATE FILED (Month, Day, Year) NOV 17 1994		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

REG. NO.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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94 33852

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARONNET Hance STOCKSDALE				2. DATE OF DEATH MONTH NOV DAY 16 YEAR 1994		3. TIME OF DEATH 5:30 A.M.	
4. SOCIAL SECURITY NUMBER 386-14-9161		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 90 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 20 1904	
8. BIRTHPLACE (State or Foreign Country) Maryland		9a. FACILITY NAME (If not institution, give street and number) Manor Care Ruxton		9b. CITY, TOWN OR LOCATION OF DEATH Towson		9c. COUNTY OF DEATH Baltimore	
10a. STATE Maryland				10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore, Maryland	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 113 E. Northern Parkway			
10f. ZIP CODE 21212				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 1 College (1-4 or 5+) 1		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Richard (NMN) Hance				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lilly Lomax Laveille			
19a. INFORMANT'S NAME (Type/Print) Alan Stocksdale				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 635 Sussex Road Towson, Maryland 21286			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Druid Ridge Cemetery 11/19/94		20c. LOCATION — City or Town, State Pikesville, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Stu T. Zetter				22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home, Inc. 6500 York Road Baltimore, Maryland 21212			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Respiratory failure							
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
a. DUE TO (OR AS A CONSEQUENCE OF): CVA							
b. DUE TO (OR AS A CONSEQUENCE OF): ASCVD							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER B. B. B. M.				29c. LICENSE NUMBER D22789		29d. DATE SIGNED (Month, Day, Year) 11/16/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 22) (Type, Print) Stu T. Zetter 3333 N. Calvert St. Balt. 21218							
31. DATE FILED (Month, Day, Year) NOV 17 1994				32. REGISTRAR'S SIGNATURE J. H. H. H.			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Rae P. Shoelman</i>				2. DATE OF DEATH MONTH DAY YEAR <i>Nov 12 1994</i>		3. TIME OF DEATH <i>12:30 A M</i>	
4. SOCIAL SECURITY NUMBER <i>216-03-6489</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>92</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>July 4, 1902</i>	
8. FACILITY NAME (If not institution, give street and number) <i>Sinai Hospital</i>				9. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>		10. COUNTY OF DEATH <i>Baltimore City</i>	
11. RESIDENCE OF DECEDENT				12. STATE <i>MD</i>		13. COUNTY <i>BALTIMORE</i>	
14. STREET AND NUMBER <i>2500 W. BELVEDERE AVE, APT. 505</i>				15. ZIP CODE <i>21215</i>		16. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
17. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		18. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		19. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		20. RACE — American Indian, Black, White, etc. Specify: <i>WHITE</i>	
21. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i></i>				22. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>LEGAL SECRETARY</i>		23. KIND OF BUSINESS/INDUSTRY <i>LAW</i>	
24. FATHER'S NAME (First, Middle, Last) <i>ISAAC PLIMACK</i>				25. MOTHER'S NAME (First, Middle, Maiden Surname) <i>JENNIE SILVERMAN</i>			
26. INFORMANT'S NAME (Type/Print) <i>MRS. CAROLE S. PERLMAN</i>				27. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>4842 HEWN TIMBER LANE, COLUMBUS, OH 43230</i>			
28. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		29. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>SHAAREI TFILOH</i>		30. DATE <i>11-14-94</i>		31. LOCATION — City or Town, State <i>BALTIMORE, MD</i>	
32. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Joel D. Lewis</i>				33. NAME AND ADDRESS OF FACILITY <i>SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>s. Thrombotic Thrombocytopenic Purpura</i> DUE TO (OR AS A CONSEQUENCE OF): <i>2 wks</i> SEQUENTIALLY list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <i>b. Insulin dependent DM</i> DUE TO (OR AS A CONSEQUENCE OF): <i>> 1 yr</i> { <i>c. DUE TO (OR AS A CONSEQUENCE OF):</i> { <i>d. DUE TO (OR AS A CONSEQUENCE OF):</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>seizure D/O</i> <i>hypothyroidism</i> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
34. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		35. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
36. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		37. DATE OF INJURY (Month, Day, Year)		38. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO		39. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
39. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		40. DESCRIBE HOW INJURY OCCURRED					
41. LOCATION (Street and Number or Rural Route Number, City or Town, State)		42. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Vincent Lee MD</i>				29c. LICENSE NUMBER <i>AS-2402821</i>		29d. DATE SIGNED (Month, Day, Year) <i>Nov 12, 1994</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Vincent Lee MD / Sinai Hospital</i>							
31. DATE FILED (Month, Day, Year) <i>NOV 17 1994</i>				32. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33854

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) DONOVAN SCOTT, JR.				2. DATE OF DEATH MONTH DAY YEAR NOV. 12 1994		3. TIME OF DEATH 1335 P M	
4. SOCIAL SECURITY NUMBER 219-40-2065		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 49 YRS.		7. DATE OF BIRTH (Month, Day, Year) MAY 3 1945	
9a. FACILITY NAME (If not institution, give street and number) 725 N. FULTON AVENUE				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 725 NORTH FULTON AVENUE				10f. ZIP CODE 21217		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SANITATION WORKER		16b. KIND OF BUSINESS/INDUSTRY Collection/city			
17. FATHER'S NAME (First, Middle, Last) DONOVAN SCOTT, SR				18. MOTHER'S NAME (First, Middle, Maiden Surname) LELIA JOHNSON			
19a. INFORMANT'S NAME (Type/Print) ANNIE McDONALD				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3901 CARLISE AVE, BALTO, MD. 21216			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT. ZION CEMETERY		20c. LOCATION — City or Town, State LANSDOWNE, MD		20d. LOCATION — City or Town, State LANSDOWNE, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Joseph L. Russ</i>				22. NAME AND ADDRESS OF FACILITY JOSEPH L. RUSS FUNERAL HOME 2222 West North Ave, Balto, MD. 21216			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. FATTY LIVER DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. ALCOHOLISM DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence 5 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29a. SIGNATURE AND TITLE OF CERTIFIER <i>Mario F. Golie Jr.</i>				29b. LICENSE NUMBER O.C.M.E.		29c. DATE SIGNED (Month, Day, Year) NOV. 13, 1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mario F. Golie Jr. M.D. 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) NOV 17 1994				32. REGISTRAR'S SIGNATURE <i>John B. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ARUN B. SAPRE				2. DATE OF DEATH MONTH DAY YEAR NOV 13 1994				3. TIME OF DEATH 7:15 P.M.	
4. SOCIAL SECURITY NUMBER 270-46-4549		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 57 YRS.		7. DATE OF BIRTH (Month, Day, Year) 2-6-37		8. BIRTHPLACE (State or Foreign Country) India	
9a. FACILITY NAME (If not institution, give street and number) GREATER BALTIMORE MEDICAL CTR				9b. CITY, TOWN OR LOCATION OF DEATH Towson				9c. COUNTY OF DEATH BALTIMORE	
RESIDENCE OF DECEDENT									
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Hunt Valley				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 19 Jonathan Ct.				10f. ZIP CODE 21030		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Army Reserve		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Indian			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 16 yrs College (1-4 or 5+) 16 yrs				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Neuro-Surgeon		16b. KIND OF BUSINESS/INDUSTRY Medicine-Surgery			
17. FATHER'S NAME (First, Middle, Last) Balkrishna L. Sapre				18. MOTHER'S NAME (First, Middle, Maiden Surname) Narmada Balsule					
19a. INFORMANT'S NAME (Type/Print) Tonya T. Sapre				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19 Jonathan Ct. Hunt Valley, Md. 21030					
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hilltop Service Corp. 11-15		20c. LOCATION — City or Town, State Towson, Md.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO									
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER O.C.M.E		29d. DATE SIGNED (Month, Day, Year) NOV 14, 1994			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201									
31. DATE FILED (Month, Day, Year) NOV 17 1994				32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33856

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ELIZABETH MILLER STEVENS				2. DATE OF DEATH MONTH 11 - DAY 6 - YEAR 94		3. TIME OF DEATH 9:40P M	
4. SOCIAL SECURITY NUMBER 213 40 1257		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 50 YRS.		7. DATE OF BIRTH (Month, Day, Year) 2-19-44	
9a. FACILITY NAME (If not institution, give street and number) 206 Deer Fox Lane				9b. CITY, TOWN OR LOCATION OF DEATH Timonium		9c. COUNTY OF DEATH Baltimore Co	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Baltimore County		10c. CITY, TOWN OR LOCATION Timonium		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 206 Deer Fox Lane				10f. ZIP CODE 21093		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES No		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12+ College (1-4 or 5+) 1		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Insurance Administrator		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) William Emil Miller				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lillian Ruth Jessop			
19a. INFORMANT'S NAME (Type/Print) John Stevens				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 206 DeerFox Lane, Timonium, MD 21093			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ronald Wade, Dir</i>				22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655W. Baltimore St, Balto, MD 21201			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Carcinoma of Lung DUE TO (OR AS A CONSEQUENCE OF): Cerebral Emboli. Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF):							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Diaz</i> MD				29c. LICENSE NUMBER D04126		29d. DATE SIGNED (Month, Day, Year) 11/10/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR DIAZ 7401 Osler Dr #103, Towson, MD 21204							
31. DATE FILED (Month, Day, Year) NOV 17 1994				32. REGISTRAR'S SIGNATURE <i>Michael R. Bell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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94 33857

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) RUTH N. TESTERMAN				2. DATE OF DEATH MONTH November DAY 15, 94 YEAR		3. TIME OF DEATH 2;10 P. M	
4. SOCIAL SECURITY NUMBER 213-26-1604		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 89 YRS.		7. DATE OF BIRTH (Month, Day, Year) December 1, 04	
8. BIRTHPLACE (State or Foreign Country) Carroll Co. Md.				9a. FACILITY NAME (If not institution, give street and number) Cherrywood Manor Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH Reisterstown	
9c. COUNTY OF DEATH Baltimore				10a. STATE Md.		10b. COUNTY Baltimore	
10c. CITY, TOWN OR LOCATION Owings Mills				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 45 Fennington Circle	
10f. ZIP CODE 21117				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5 +)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) Samuel M. Sprague				18. MOTHER'S NAME (First, Middle, Maiden Surname) Agnes E. Warner			
19a. INFORMANT'S NAME (Type/Print) Mrs. Ann R. Mettee				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7060 Macbeth Way Sykesville, Md. 21784			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lakeview Memorial Park 11-18-94		20c. LOCATION — City or Town, State Sykesville, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Eline</i>				22. NAME AND ADDRESS OF FACILITY 11824 Reisterstown Rd. Eline Funeral Home Reisterstown, Md. 21136			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → s. <u>Dementia - Alzheimer</u> DUE TO (OR AS A CONSEQUENCE OF): b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Parkinsons Syndrome, Aspiration Pneumonias</u>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Gary A. Manko</i>				29c. LICENSE NUMBER 025062		29d. DATE SIGNED (Month, Day, Year) 11-16-1994	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Gary A. Manko M.D. 750 Main Street Reisterstown, Md. 21136							
31. DATE FILED (Month, Day, Year) NOV 17 1994				32. REGISTRAR'S SIGNATURE <i>John Benison-Funder</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

94 33858

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Willetta Teal</u>				2. DATE OF DEATH <u>NOV 16 1994</u>		3. TIME OF DEATH <u>1:45 A</u>	
4. SOCIAL SECURITY NUMBER <u>212-22-5261</u>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>84</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>MAR. 24, 1910</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>LEVINDALE NURSING HOME</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>BALTIMORE</u>		9c. COUNTY OF DEATH <u>n/a</u>	
RESIDENCE OF DECEDENT							
10a. STATE <u>MARYLAND</u>		10b. COUNTY <u>n/a</u>		10c. CITY, TOWN OR LOCATION <u>BALTIMORE</u>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <u>1510 MOSHER STREET</u>				10f. ZIP CODE <u>21217</u>		10g. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>BLACK</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>HIGHSCHOOL</u> College (1-4 or 5+) <u>-</u>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>LABORER</u>		16b. KIND OF BUSINESS/INDUSTRY <u>RESTAURANT</u>	
17. FATHER'S NAME (First, Middle, Last) <u>WILLIAM MASON</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>LUEMMA MASON</u>			
19a. INFORMANT'S NAME (Type/Print) <u>VIRGINIA MORRIS</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1510 MOSHER STRR, BALTIMORE, MARYLAND apt. 7E#17</u>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) <u>WESTERN STAR CEMETERY 11-19</u>		20c. LOCATION — City or Town, State <u>CATONSVILLE, MD</u>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>[Signature]</u>				22. NAME AND ADDRESS OF FACILITY <u>WM. C. MARCH FH.-1101 E. NORTH AVENUE</u>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>CARDIAC ARREST</u> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <u>SEPTICEMIA</u> <u>PERIPHERAL VASCULAR DISEASE</u> <u>ISCHEMIC BOWEL</u> <u>MALNUTRITION</u>							Approximate Interval Between Onset and Death <u>minutes</u> <u>5 days</u>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>PERIPHERAL VASCULAR DISEASE</u> <u>ISCHEMIC BOWEL</u> <u>MALNUTRITION</u>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28b. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28c. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Matthew McNabney MD</u>				29c. LICENSE NUMBER <u>D45757</u>		29d. DATE SIGNED (Month, Day, Year) <u>11-16-94</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>MATTHEW MCNABNEY, MD 2434 W. BELVEDERE, BALT.</u>							
31. DATE FILED (Month, Day, Year) <u>NOV 17 1994</u>				32. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) DOROTHY Margaret Tonarelli		2. DATE OF DEATH MONTH 11 DAY 16 YEAR 1994		3. TIME OF DEATH 2:37 AM	
4. SOCIAL SECURITY NUMBER 215-14-9593		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.	
7. DATE OF BIRTH (Month, Day, Year) 05/02/22		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) Harbor Hospital Center		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH NA	
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Baltimore (Baltimore Highlands)	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 3002 Delaware Avenue,		10f. ZIP CODE 21227	
10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 9th Grade		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Housewife and Mother	
17. FATHER'S NAME (First, Middle, Last) John Kinstler		18. MOTHER'S NAME (First, Middle, Maiden Surname) Annabelle Skynes			
19a. INFORMANT'S NAME (Type/Print) Mr. Dean Tonarelli		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3002 Delaware Ave., Baltimore, Md. 21227			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Meadowridge Mem. Pk. 11/19		20c. LOCATION — City or Town, State Elkridge, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Kevin E. Ecker		22. NAME AND ADDRESS OF FACILITY McCully Funeral Home of Brooklyn 237 E. Patapsco Ave., Balto., Md. 21225			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → RESPIRATORY FAILURE DUE TO (OR AS A CONSEQUENCE OF): Perforated diverticulitis DUE TO (OR AS A CONSEQUENCE OF): Arteriosclerotic cardiovascular disease DUE TO (OR AS A CONSEQUENCE OF): SEVERE COPD Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST					Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MALNUTRITION WOUND INFECTION					24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER John R. Arguillano Md		29c. LICENSE NUMBER D28988		29d. DATE SIGNED (Month, Day, Year) 11-16-94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Lino R. Arguillano Md, 3001 S. Harpover St. Balt. Md.					
31. DATE FILED (Month, Day, Year) NOV 17 1994		32. REGISTRAR'S SIGNATURE John R. Arguillano			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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100N

x

x

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94 33860

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                                                                  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>FLORENCE ELLA THISTLE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>13</b> YEAR <b>94</b>                                                                                                                                |  | 3. TIME OF DEATH<br><b>5:25P M</b>                                                          |                                                                                                                  |
| 4. SOCIAL SECURITY NUMBER<br><b>014 22 3444</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>71</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>8-9-23</b>                                        |                                                                                                                  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Dennett Road Manor</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Oakland</b>                                                                                                                                           |  | 9c. COUNTY OF DEATH<br><b>Garrett Co</b>                                                    |                                                                                                                  |
| 10a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  | 10b. COUNTY<br><b>Garrett Co</b>                                                                                                                                                                |  | 10c. CITY, TOWN OR LOCATION<br><b>Oakland</b>                                               |                                                                                                                  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  | 10e. STREET AND NUMBER<br><b>1113 Mary Drive</b>                                                                                                                                                |  |                                                                                             |                                                                                                                  |
| 10f. ZIP CODE<br><b>21550</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                     |  |                                                                                             |                                                                                                                  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>No</b>                                                                                                                                   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                  |                                                                                                                  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>12</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Factory Worker</b>                                                                                                                                                            |  | 16b. KIND OF BUSINESS/INDUSTRY                                                                                                                                                                  |  |                                                                                             |                                                                                                                  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John William Beckett</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Vivian Theresa Chapman</b>                                                                                                              |  |                                                                                             |                                                                                                                  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Nancy Sisk</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>47 Somerville Ave, Cumberland, MD 21502</b>                                                 |  |                                                                                             |                                                                                                                  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                             |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>DATE</b>                                                                                                                                                                                                 |  | 20c. LOCATION — City or Town, State                                                                                                                                                             |  |                                                                                             |                                                                                                                  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Ronald Wade, Dir</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>State Anatomy Board<br/>655W. Baltimore St, Balto, MD 21201</b>                                                                                          |  |                                                                                             |                                                                                                                  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. acute and chronic urosepsis 1 week/years</b><br><b>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</b><br>b. <b>diabetes mellitus type 2 years</b><br>c. <b>old cerebral vascular accident</b><br>d. |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             | Approximate Interval Between Onset and Death                                                                     |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>multiple stage 4 decubiti, dementia, COPD,</b>                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO            |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 28. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                                                                  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                     |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |                                                                                                                  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                    |  |                                                                                             |                                                                                                                  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                                                                  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Margaret A. Kaiser, M.D.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>D26650</b>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/13/94</b>                                      |                                                                                                                  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Margaret Kaiser, M.D., P.O. Box 486, Oakland, Md 21550</b>                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                                                                  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 17 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  | 32. REGISTRAR'S SIGNATURE<br><i>Shirley A. ...</i>                                                                                                                                              |  |                                                                                             |                                                                                                                  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

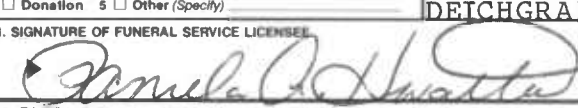
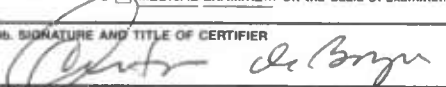
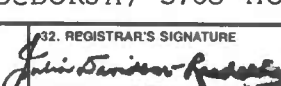
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33861

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                             |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>DORIS MAE VERNON                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                            |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>NOVEMBER 14, 1994                                                                                                                                             |  | 3. TIME OF DEATH<br>1:32 P M                                                                        |                                                                                                                                             |
| 4. SOCIAL SECURITY NUMBER<br>216-34-3583                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                             |  | 6. AGE (In yrs. last birthday)<br>57 YRS.                                                                                                                                                           |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>08-20-1937                                                |                                                                                                                                             |
| 8. BIRTHPLACE (State or Foreign Country)<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 9a. FACILITY NAME (If not institution, give street and number)<br>22 HANFORD DRIVE                                                                                                                                                                                                                         |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>HARMANS                                                                                                                                                      |  | 9c. COUNTY OF DEATH<br>ANNE ARUNDEL                                                                 |                                                                                                                                             |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                             |
| 10a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 10b. COUNTY<br>ANNE ARUNDEL                                                                                                                                                                                                                                                                                |  | 10c. CITY, TOWN OR LOCATION<br>HARMANS                                                                                                                                                              |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |                                                                                                                                             |
| 10e. STREET AND NUMBER<br>22 HANFORD DRIVE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |  | 10f. ZIP CODE<br>21077                                                                                                                                                                              |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                             |                                                                                                                                             |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                           |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: WHITE                                    |                                                                                                                                             |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 9<br>College (1-4 or 5+) NONE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>HOMEMAKER                                                                                                                                                                                 |  | 16b. KIND OF BUSINESS/INDUSTRY<br>OWN HOME                                                                                                                                                          |  |                                                                                                     |                                                                                                                                             |
| 17. FATHER'S NAME (First, Middle, Last)<br>ROBERT T. BATEMAN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>DORIS LORRAINE KNIGHT                                                                                                                          |  |                                                                                                     |                                                                                                                                             |
| 19a. INFORMANT'S NAME (Type/Print)<br>CHARLES W. VERNON                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>22 HANFORD DRIVE, HARMANS, MARYLAND 21077                                                          |  |                                                                                                     |                                                                                                                                             |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>11/18/94<br>DEICHGRABER FAMILY CEMETERY SEVERN, MARYLAND                                                                                                                                                                |  | 20c. LOCATION — City or Town, State                                                                                                                                                                 |  |                                                                                                     |                                                                                                                                             |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br>SINGLETON FUNERAL HOME<br>1 SECOND AVENUE, S.W.<br>GLEN BURNIE, MARYLAND 21061                                                                                  |  |                                                                                                     |                                                                                                                                             |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>End Stage obstructive lung disease</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     | Approximate Interval Between Onset and Death                                                                                                |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                              |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                             |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                      |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                     |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                            |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |                                                                                                                                             |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                             |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                               |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                             |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                             |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br> M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  | 29c. LICENSE NUMBER<br>D 42820                                                                                                                                                                      |  | 29d. DATE SIGNED (Month, Day, Year)<br>11/16/94                                                     |                                                                                                                                             |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>CHRISTOPHER DeBORJA, 3708 MOUNTAIN ROAD, PASADENA, MD. 21122                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                             |
| 31. DATE FILED (Month, Day, Year)<br>NOV 17 1994                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                            |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                    |  |                                                                                                     |                                                                                                                                             |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





94 33862

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                         |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>FREDERICK A VAUGHN</b>                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>15</b> YEAR <b>1994</b>                                                                                                                              |  | 3. TIME OF DEATH<br><b>4:35 a</b>                                                               |                                                                                                                                         |
| 4. SOCIAL SECURITY NUMBER<br><b>228-22-7854</b>                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>70</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>AUG. 18, 1924</b>                                     |                                                                                                                                         |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>GREATER BALTIMORE MEDICAL CENTER</b>                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>TOWSON</b>                                                                                                                                            |  | 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>                                                         |                                                                                                                                         |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                         |
| 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 10b. COUNTY<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                |  | 10c. CITY, TOWN OR LOCATION<br><b>TIMONIUM</b>                                                                                                                                                  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |                                                                                                                                         |
| 10e. STREET AND NUMBER<br><b>312 FIVE FARMS LANE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  | 10f. ZIP CODE<br><b>21093</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                     |                                                                                                                                         |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                          |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WW II</b>                                                                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>                      |                                                                                                                                         |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>4</b>                                                                                                                                                                                                                                                                                                                                             |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>MANAGER</b>                                                                                                                                                                |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>MANUFACTURING</b>                                                                                                                                          |  |                                                                                                 |                                                                                                                                         |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>CHARLES E. VAUGHN</b>                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MINNIE L. PITTS</b>                                                                                                                     |  |                                                                                                 |                                                                                                                                         |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MARY VIRGINIA VAUGHN</b>                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>312 FIVE FARMS LANE TIMONIUM, MD. 21093</b>                                                 |  |                                                                                                 |                                                                                                                                         |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>HILLTOP SERVICE CORP. 11/19/94</b>                                                                                                                                                                       |  | 20c. LOCATION — City or Town, State<br><b>TOWSON, MD.</b>                                                                                                                                       |  |                                                                                                 |                                                                                                                                         |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>John E. Dolan</i> <b>JOHN E. DOLAN</b>                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>RUCK TOWSON FUNERAL HOME INC.<br/>1050 YORK ROAD TOWSON, MD. 21204</b>                                                                                   |  |                                                                                                 |                                                                                                                                         |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>SEPSIS</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>NON HODGKINS LYMPHOMA</b> |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 | Approximate Interval Between Onset and Death<br><b>4 yrs</b>                                                                            |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>HEPATIC FAILURE</b>                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                       |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                         |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                              |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |                                                                                                                                         |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                          |  |                                                                                                 |                                                                                                                                         |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                    |  |                                                                                                 |                                                                                                                                         |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                         |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>G. I. Ch MD</i>                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>027730</b>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/15/94</b>                                          |                                                                                                                                         |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>GARY COLLEN, MD 6569 N. CHARLES ST. BALTIMORE, MD 21204</b>                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                         |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 17 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  | REGISTRAR'S SIGNATURE<br><i>John B. ...</i>                                                                                                                                                     |  |                                                                                                 |                                                                                                                                         |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33863

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                 |  |                                                                                                                                             |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Baby Girl Locklear</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                  |  | 2. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>13</b> YEAR <b>1994</b>                                                                                                                                                                                                                                         |  |                                 |  | 3. TIME OF DEATH<br><b>1250 A.M.</b>                                                                                                        |  |
| 4. SOCIAL SECURITY NUMBER<br><b>N/A</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                   |  | 8. AGE (In yrs. last birthday)<br>YRS.                                                                                                                                                                                                                                                                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN.                                                                                                              |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>JHBM</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                    |  |                                 |  | 9c. COUNTY OF DEATH                                                                                                                         |  |
| 10a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                  |  | 10b. COUNTY                                                                                                                                                                                                                                                                                                |  |                                 |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                                                                                             |  |
| 10e. STREET AND NUMBER<br><b>1714 Dundalk Ave.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                  |  | 10f. ZIP CODE<br><b>21222</b>                                                                                                                                                                                                                                                                              |  |                                 |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                 |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: <b>Puerto Rican</b>                                                                                      |  |                                 |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Am. Ind.</b>                                                                  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>N/A</b> College (1-4 or 5+) <b>N/A</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>N/A</b>                                                                                                                                                                                   |  |                                 |  | 16b. KIND OF BUSINESS/INDUSTRY                                                                                                              |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Tomas Villarreal</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Crystal A. Locklear</b>                                                                                                                                                                                                                            |  |                                 |  |                                                                                                                                             |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mary Laberia</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1714 Dundalk Ave. Baltimore, MD. 21222</b>                                                                                                                                                             |  |                                 |  |                                                                                                                                             |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Oaklawn Cemetery 11-15 Baltimore, Md.</b>                                                                                                                                                                            |  |                                 |  | 20c. LOCATION — City or Town, State                                                                                                         |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Kathleen Weber</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>David J. Weber Funeral Home<br/>401 S. Chester Street Baltimore, MD. 21231</b>                                                                                                                                                                                      |  |                                 |  |                                                                                                                                             |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Extreme Prematurity</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Pulmonary Hypoplasia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Respiratory Distress Syndrome</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                 |  | Approximate Interval Between Onset and Death                                                                                                |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                 |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                 |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                 |  |                                                                                                                                             |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                  |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                     |  | 28b. TIME OF INJURY<br><b>M</b> |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                  |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                          |  |                                 |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                   |  |                                                                                                                                                  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>G. Alpan MD</i>                                                                                                                                                                                                                                                |  |                                 |  | 29c. LICENSE NUMBER<br><b>D42096</b>                                                                                                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/13/94</b>                                                                                                                                                                                                                                                     |  |                                 |  |                                                                                                                                             |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>4940 Eastern Ave. (DR. G. ALPAN); Baltimore, MD 21224</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                 |  |                                                                                                                                             |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 17 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                  |  | 32. REGISTRAR'S SIGNATURE<br><i>John S. Sanders</i>                                                                                                                                                                                                                                                        |  |                                 |  |                                                                                                                                             |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



ITEM: 23 PART II, PER MEO FILM G-720 2/6/95 t.t

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                        |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>AUBREY E. WAINWRIGHT</b>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOV. 03, 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 3. TIME OF DEATH<br><b>12:30 A.M.</b>                                                                                                                                                  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>257-98-7372</b>                                                                                                                                                                                                                                                                                                                                                                                  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>35</b> YRS.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>July 25, 1959</b>                                                                                                                         |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Ohio</b>                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>103 ALMSHOUSE ROAD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Cockeysville</b>                                                                                                                             |  |
| 9c. COUNTY OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                |  | 10a. STATE<br><b>PA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 10b. COUNTY<br><b>York</b>                                                                                                                                                             |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Glen Rock</b>                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 10e. STREET AND NUMBER<br><b>28 Pine Street</b>                                                                                                                                        |  |
| 10f. ZIP CODE<br><b>17327</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                                 |  |                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                        |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                        |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Carpenter</b>                                                                                                                                                                                                                                                                                                |  |                                                                                |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Baltimore County Dept. Central Services</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                        |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Palmer L. Wainwright</b>                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ruth L. Wright</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                        |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Laura L. Wainwright</b>                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>28 Pine St., Glen Rock, PA 17327</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                        |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                  |  |                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Moreland Memorial Park Cem. NOV 5 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                        |  |
| 20c. LOCATION — City or Town, State<br><b>Baltimore, MD</b>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>J.J. Hartenstein</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>J.J. Hartenstein Mortuary, Inc.<br/>24 Second St., New Freedom, PA 17349</b>                                                                                                                                                                                                                                                                                                              |  |                                                                                |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Contact Gunshot Wound of Head</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                        |  |
| 23. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>BIPOLAR DISORDER</b>                                                                                                                                                                                                                                                                            |  |                                                                                |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                        |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                      |  |                                                                                |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                        |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>103 Alms House Rd</b>                                                                                              |  |                                                                                |  | 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                        |  |
| 28a. DATE OF INJURY<br>(Month/Day/Year)<br><b>Found 11-2-94</b>                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                |  | 28b. TIME OF INJURY<br>(Month/Day/Year)<br><b>11:37 P.M.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                        |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                             |  |                                                                                |  | 28d. DESCRIBE HOW INJURY OCCURRED<br><b>subject shot self</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>parking lot</b>                                                                                                                                                                                                                                                                                                                     |  |                                                                                |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>103 Alms House Rd<br/>Cockeysville, Md</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Kevin J. Chute MD</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                        |  |
| 29c. LICENSE NUMBER<br><b>OCME</b>                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11-17-94</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                        |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>111 Penn Street Baltimore, Md 21201</b>                                                                                                                                                                                                                                                                                                |  |                                                                                |  | 31. DATE FILED (Month, Day, Year)<br><b>NOV 17 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
| 32. REGISTRAR'S SIGNATURE<br><i>John Sanders-Russell</i>                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                        |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

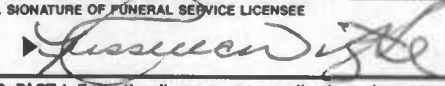
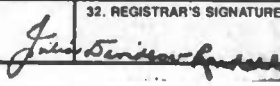
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33865

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                                                             |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>SLOANE DENISE YOUNG                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>NOV. 15 1994                                                                                                                                                  |  | 3. TIME OF DEATH<br>6:45 P M                                                                                                                |  |
| 4. SOCIAL SECURITY NUMBER<br>216-06-5490                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                             |  | 6. AGE (In yrs. last birthday)<br>10 YRS.                                                                                                                                                           |  | 7. DATE OF BIRTH (Month, Day, Year)<br>JUNE 6, 1984                                                                                         |  |
| 8a. FACILITY NAME (If not institution, give street and number)<br>9502 DEERFOOT WAY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br>COLUMBIA                                                                                                                                                     |  | 8c. COUNTY OF DEATH<br>HOWARD                                                                                                               |  |
| 9. RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |  | 10a. STATE<br>MD                                                                                                                                                                                    |  | 10b. COUNTY<br>HOWARD                                                                                                                       |  |
| 10c. CITY, TOWN OR LOCATION<br>COLUMBIA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                 |  |                                                                                                                                             |  |
| 10e. STREET AND NUMBER<br>9502 DEERFOOT WAY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |  | 10f. ZIP CODE<br>21046                                                                                                                                                                              |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                        |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                           |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>BLACK                                                                         |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 4<br>College (1-4 or 5+) NONE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>NONE                                                                                                                                                                                         |  | 16b. KIND OF BUSINESS/INDUSTRY<br>NONE                                                                                                                                                              |  |                                                                                                                                             |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>UNKNOWN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>UNKNOWN                                                                                                                                        |  |                                                                                                                                             |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>DELROY L. CORNICK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>9502 DEERFOOT WAY, COLUMBIA, MD. 21046                                                             |  |                                                                                                                                             |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                             |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>COLUMBIA MEM. PARK NOV 19, 1994 CLARKSVILLE, MD.                                                                                                                                                                        |  | 20c. LOCATION — City or Town, State                                                                                                                                                                 |  |                                                                                                                                             |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br>LEROY M & RUSSELL C WITZKE FUNERAL HOME<br>5555 TWIN KNOLLS RD. COLUMBIA, MD 21045                                                                              |  |                                                                                                                                             |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. RESPIRATORY FAILURE<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. PNEUMONIA<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. BRAIN STEM GLIOMA<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  | Approximate Interval Between Onset and Death                                                                                                |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                                                                             |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                   |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                     |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                            |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                          |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                              |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                                                             |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Christopher N. Frantz MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                            |  | 29c. LICENSE NUMBER<br>D39666                                                                                                                                                                       |  | 29d. DATE SIGNED (Month, Day, Year)<br>11/16/94                                                                                             |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>CHRISTOPHER N. FRANTZ MD 22 S. GREEN ST. BALTIMORE MD 21201                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                                                             |  |
| 31. DATE FILED (Month, Day, Year)<br>NOV 17 1994                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                    |  |                                                                                                                                             |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

21-11-2018

21-11-2018



94 33866

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                             |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Louise YOSKOSKY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>November 15, 1994                                                                                                                                             |  | 3. TIME OF DEATH<br>8:50 P M                                                                        |                                                                                                                                             |
| 4. SOCIAL SECURITY NUMBER<br>213-48-4281                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                             |  | 8. AGE (In yrs. last birthday)<br>88 YRS.                                                                                                                                                           |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>April 13, 1994                                            |                                                                                                                                             |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Franklin Square Hospital                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Rossville                                                                                                                                                    |  | 9c. COUNTY OF DEATH<br>Baltimore                                                                    |                                                                                                                                             |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                             |
| 10a. STATE<br>MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 10b. COUNTY<br>Baltimore                                                                                                                                                                                                                                                                                   |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore                                                                                                                                                            |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |                                                                                                                                             |
| 10e. STREET AND NUMBER<br>4604 Charles Avenue                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                            |  | 10f. ZIP CODE<br>21206                                                                                                                                                                              |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A                                                              |                                                                                                                                             |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                           |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                    |                                                                                                                                             |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Housewife                                                                          |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Home                                                              |                                                                                                                                             |
| 17. FATHER'S NAME (First, Middle, Last)<br>Louis Fontain                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Rose Whitney                                                                                                                                   |  |                                                                                                     |                                                                                                                                             |
| 19a. INFORMANT'S NAME (Type/Print)<br>Gladys Ewers                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4604 Charles Ave Balto. MD. 21206                                                                  |  |                                                                                                     |                                                                                                                                             |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Greenmount Crematory 11/17/94                                                                                    |  | 20c. LOCATION — City or Town, State<br>Baltimore, Md.                                               |                                                                                                                                             |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>John J. Dippel</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br>The Dippel Funeral Home Inc.<br>7110 Belair Road Baltimore, MD 21206                                                                                            |  |                                                                                                     |                                                                                                                                             |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Dehydration, hypernatremia<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     | Approximate Interval Between Onset and Death<br>5 days                                                                                      |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                             |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                           |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                     |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                            |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |                                                                                                                                             |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  | 28d. DESCRIBE HOW INJURY OCCURED                                                                                                                                                                    |  |                                                                                                     |                                                                                                                                             |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                        |  |                                                                                                     |                                                                                                                                             |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                             |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Richard Safeer MD</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                            |  | 29c. LICENSE NUMBER<br>RD1664                                                                                                                                                                       |  | 29d. DATE SIGNED (Month, Day, Year)<br>11/15/94                                                     |                                                                                                                                             |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Dr. Richard Safeer 9000 Franklin Square Dr. Baltimore, Maryland 21237                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                             |
| 31. DATE FILED (Month, Day, Year)<br>NOV 17 1994                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |  | 32. REGISTRAR'S SIGNATURE<br><i>John Benbow Rudebeck</i>                                                                                                                                            |  |                                                                                                     |                                                                                                                                             |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                 |                                                         |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|---------------------------------------------------------|
| 1. DECEASED'S NAME (First, Middle, Last)<br>Nicholas NMN Zornak                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>Nov. 12, 1994                                                                                                                                                 |  | 3. TIME OF DEATH<br>9:15.A. M                                                                   |                                                         |
| 4. SOCIAL SECURITY NUMBER<br>215-07-4732                                                                                                                                                                                                                                                                                                                                                                                         |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                                 |  | 6. AGE (In yrs. last birthday)<br>80 YRS.                                                                                                                                                           |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>2/16/1914                                             |                                                         |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Harbor Hospital Center                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Balto. City, Md.                                                                                                                                             |  | 9c. COUNTY OF DEATH<br>-----                                                                    |                                                         |
| RESIDENCE OF DECEASED                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                 |                                                         |
| 10a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                           |  | 10b. COUNTY<br>-----                                                                                                                                                                                                                                                                                       |  | 10c. CITY, TOWN OR LOCATION<br>Balto. City, Md.                                                                                                                                                     |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |                                                         |
| 10e. STREET AND NUMBER<br>1810 Jackson St.                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                            |  | 10f. ZIP CODE<br>21230                                                                                                                                                                              |  | 10g. CITIZEN OF WHAT COUNTRY?<br>United States                                                  |                                                         |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                           |  | 12. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                        |  | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                |                                                         |
| 15. DECEASED'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>8th. Grade                                                                                                                                                                                                                                                                                                                  |  | 15a. DECEASED'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Ship Fitter                                                                                                                                                                               |  | 15b. KIND OF BUSINESS/INDUSTRY<br>Bethlehem Steel                                                                                                                                                   |  |                                                                                                 |                                                         |
| 17. FATHER'S NAME (First, Middle, Last)<br>Anton Zornak                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Magdalene Hugel                                                                                                                                |  |                                                                                                 |                                                         |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mrs. Dolores A. Zornak                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1810 Jackson St. Balto. Md. 21230                                                                  |  |                                                                                                 |                                                         |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Metro Crematory, Inc. 11/14/94                                                                                                                                                                                          |  | 20c. LOCATION — City or Town, State<br>Catonsville, Md.                                                                                                                                             |  | 20d. DATE<br>11/14/94                                                                           |                                                         |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Daniel A. Taylor                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br>Balto. Md. 21230<br>McCully Funeral Home, 130 E. Fort Ave.                                                                                                      |  |                                                                                                 |                                                         |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                 |                                                         |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →                                                                                                                                                                                                                                                                                                                                                                |  | a. Cerebrovascular Accident                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                     |  |                                                                                                 | Approximate Interval Between Onset and Death<br>12 hrs. |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                          |  | b. Hypertensive Atherosclerotic Cardiovascular Disease                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                     |  |                                                                                                 | 10 yrs.                                                 |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | c. Atrial Fibrillation                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                     |  |                                                                                                 |                                                         |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | d.                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                                 |                                                         |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Congestive Heart Failure                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                 |                                                         |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                                 |                                                         |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide                                                                                                                                        |  | 28a. DATE OF INJURY<br>(Month, Day, Year)                                                                                                                                                                                                                                                                  |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                            |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO            |                                                         |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                              |  |                                                                                                 |                                                         |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                 |                                                         |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                 |                                                         |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Alan N. Dennis M.D.                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |  | 29c. LICENSE NUMBER<br>D30505                                                                                                                                                                       |  | 29d. DATE SIGNED (Month, Day, Year)<br>11/13/94                                                 |                                                         |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Alan N. Dennis 707 E. Fort Ave                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                 |                                                         |
| 31. DATE FILED (Month, Day, Year)<br>NOV 17 1994                                                                                                                                                                                                                                                                                                                                                                                 |  | 32. REGISTRAR'S SIGNATURE<br>John Davidson Randall                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                                 |                                                         |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                    |  |                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                         |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>RICHARD LEO ZIPP</b>                                                                                |  |                           |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOV. 16, 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 3. TIME OF DEATH<br><b>1540 P M</b>                                                                                     |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-44-6857</b>                                                                                                    |  | 5. SEX<br><b>XX M 2 F</b> |  | 6. AGE (In yrs. last birthday)<br><b>48</b> YRS.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>APRIL 11, 1946</b>                                                            |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>                                                                                        |  |                           |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>FRANCIS SCOTT KEY BRIDGE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>                                                                 |  |
| 10a. STATE<br><b>MARYLAND</b>                                                                                                                      |  |                           |  | 10b. COUNTY<br><b>BALTIMORE CITY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE CITY</b>                                                                    |  |
| 10d. INSIDE CITY LIMITS?<br><b>1 XX YES 2 F NO</b>                                                                                                 |  |                           |  | 10e. STREET AND NUMBER<br><b>1621 CUBA STREET</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 10f. ZIP CODE<br><b>21230</b>                                                                                           |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                     |  |                           |  | 11. MARITAL STATUS<br><b>1 F Never Married 2 XX Married 3 F Widowed 4 F Divorced</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 XX YES 2 F NO</b><br>IF YES, GIVE WAR OR DATES<br><b>ARMY, VIETNAM</b> |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 F YES 2 XX NO Specify:</b> |  |                           |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12TH</b>              |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>MAIL CARRIER</b>                  |  |                           |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>U.S. POSTAL SERVICE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                         |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>ALEXANDER J. ZIPP, SR.</b>                                                                           |  |                           |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>CLEMENTINE M. SCHOENFELD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                         |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>DEBORAH A. ZIPP</b>                                                                                       |  |                           |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1621 CUBA STREET, BALTIMORE, MARYLAND 21230</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                         |  |
| 20a. METHOD OF DISPOSITION<br><b>XX Burial 2 F Cremation 3 F Removal from State 4 F Donation 5 F Other (Specify)</b>                               |  |                           |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>CROWNSVILLE VETERANS CEMETERY, NOV. 21, 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                         |  |
| 20c. LOCATION — City or Town, State<br><b>CROWNSVILLE, MARYLAND</b>                                                                                |  |                           |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                         |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>CHARLES L. STEVENS FUNERAL HOME, INC. 1501 E. FORT AVENUE, BALTIMORE, MARYLAND 21230</b>                    |  |                           |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Drowning with Chest Injuries</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                         |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><b>XX YES 2 F NO</b>                                                                                             |  |                           |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>XX YES 2 F NO</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                         |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>           |  |                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                         |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1 XX YES 2 F NO</b>                                                                               |  |                           |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>IN WATER</b>                                                                                                                                                                                                                                                                                                          |  |                                                                                                                         |  |
| 27. MANNER OF DEATH<br><b>1 F Natural 2 F Accident 3 XX Suicide 4 F Homicide 5 F Pending Investigation 6 F Could not be determined</b>             |  |                           |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>11/16/94</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                         |  |
| 28b. TIME OF INJURY<br><b>1226 M</b>                                                                                                               |  |                           |  | 28c. INJURY AT WORK?<br><b>1 F YES 2 XX NO</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                         |  |
| 28d. DESCRIBE HOW INJURY OCCURRED<br><b>Subject jumped from bridge</b>                                                                             |  |                           |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>BRIDGE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                         |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>FRANCIS SCOTKEY BRIDGE</b>                                      |  |                           |  | 29a. CERTIFIER<br>Check only one<br><b>2 XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                         |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>JARON LOCKE MD</b>                                                                                     |  |                           |  | 29c. LICENSE NUMBER<br><b>OCME</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                         |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>NOV. 17, 1994</b>                                                                                        |  |                           |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>JARON LOCKE MD 111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                         |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 17 1994</b>                                                                                            |  |                           |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                         |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33869

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>RAYMOND R. AIKEYS</b>                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>14</b> YEAR <b>94</b>                                                                                                                                |  | 3. TIME OF DEATH<br><b>11 40 P M</b>                                                            |  |
| 4. SOCIAL SECURITY NUMBER<br><b>239-18-1295</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>84</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>March 28, 1910</b>                                    |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>South Carolina</b>                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 9. COUNTY OF DEATH                                                                                                                                                                              |  |                                                                                                 |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Bayview Medical Center</b>                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>                                                                                                                                         |  | 9c. COUNTY OF DEATH                                                                             |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                |  | 10b. COUNTY                                                                                                                                                                                                                                                                                    |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                                                                                                                                                 |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>3101 Federal Street</b>                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  | 10f. ZIP CODE<br><b>21213</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                     |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                               |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>                      |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>                                                                                                                                                                                                                                                      |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Ship Fitter</b>                                                                                                                                                            |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Bethlehem Steel Corporation</b>                                                                                                                            |  |                                                                                                 |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William Aikens</b>                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Cora Richardson</b>                                                                                                                     |  |                                                                                                 |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Scarlett A. Watson</b>                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3101 Federal Street Baltimore, MD 21213</b>                                                 |  |                                                                                                 |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>King Memorial Park</b>                                                                                                                                                                                   |  | DATE<br><b>Nov 18</b>                                                                                                                                                                           |  | 20c. LOCATION — City or Town, State<br><b>Baltimore County, MD</b>                              |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Vernon R. Bailey</b>                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Nutter Funeral Homes, Inc<br/>2501 Gwynns Falls Parkway<br/>Baltimore, Maryland 21216</b>                                                                |  |                                                                                                 |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>UROSEPSIS</b>                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| a. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| b. <b>URINARY TRACT INFECTION</b><br>DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                              |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 28d. DESCRIBE HOW INJURY OCCURED                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                 |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>[Signature] M.D.</b>                                                                                                                                                                                                                               |  | 29c. LICENSE NUMBER<br><b>94007</b>                                                                                                                                                             |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/14/94</b>                                          |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DR. P.H. JEWELL 15 A VIEW MED WTR</b>                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                      |  | 32. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





94 33870

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>BERNARD CARL BATZER, SR.</b>                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                                           |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOV. 15 1994</b>                                                                                                                                           |  | 3. TIME OF DEATH<br><b>9:10P. M</b>                                                                 |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-24-3015</b>                                                                                                                                                                                                                                                                                                                                                                                     |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                                                                                                                                                                            |  | 6. AGE (In yrs. last birthday)<br><b>65</b> YRS.                                                                                                                                                    |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Sept. 08, 1929</b>                                        |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Stella Maris Hospice</b>                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                           |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Towson</b>                                                                                                                                                |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>                                                             |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                       |  | 10b. COUNTY<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                           |  | 10c. CITY, TOWN OR LOCATION<br><b>Pikesville</b>                                                                                                                                                    |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>603 Ralston Avenue</b>                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                           |  | 10f. ZIP CODE<br><b>21208</b>                                                                                                                                                                       |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                         |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                              |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                       |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                          |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>12th</b>                                                                                                                                                                                                                                                                                                                                                   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Turn Foreman</b>                                                                                                                                                                                      |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Steel Industry</b>                                                                                                                                             |  |                                                                                                     |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Louis Frederick Batzer</b>                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                           |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Lillian Mary Clements</b>                                                                                                                   |  |                                                                                                     |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mary Joan Batzer</b>                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                           |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>603 Ralston Avenue Pikesville, MD 21208</b>                                                     |  |                                                                                                     |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                     |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metro Crematory, Inc. 11/16/94</b>                                                                                                                                                                                                  |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, MD</b>                                                                                                                                         |  |                                                                                                     |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Dawn F. McDonald</b>                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                           |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Cremation Society of Maryland, Inc.<br/>299 Frederick Rd. Baltimore, MD 21228</b>                                                                            |  |                                                                                                     |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>LUNG CANCER</b>                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                               |  | 28. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b> |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide                                                                                                                                           |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                                    |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                     |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                           |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                        |  |                                                                                                     |  |
| 29a. CERTIFIER<br>(Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Kendall E Faulkner</b>                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                           |  | 29c. LICENSE NUMBER<br><b>D 25643</b>                                                                                                                                                               |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/16/94</b>                                              |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DR. KENDALL FAULKNER 2300 DULANEY VALLEY RD., TOWSON, MD 21204</b>                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                             |  | 32. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                     |  |                                                                                                     |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10



ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-718 12/2/94 t.t

1 -  
FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                  |                                                                                                                                                                                |  |                                                                                                                                              |                                                                                                       |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>TIMOTHY D. BROWN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                  | 2. DATE OF DEATH<br>MONTH <b>NOV.</b> DAY <b>15</b> YEAR <b>1994</b>                                                                                                           |  | 3. TIME OF DEATH<br><b>6:35 AM</b>                                                                                                           |                                                                                                       |
| 4. SOCIAL SECURITY NUMBER<br><b>213-86-3791</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                                                                                                                                                   | 6. AGE (In yrs. last birthday)<br><b>32</b> YRS. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Dec. 13, 1961</b>                                                                                                                 |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>MD</b>                                                                                        |                                                                                                       |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>102 N. CHARTER ROAD #F</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>GLEN BURNIE</b>                                                                                                                      |  | 9c. COUNTY OF DEATH<br><b>ANNE ARUNDEL</b>                                                                                                   |                                                                                                       |
| 10a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                  | 10b. COUNTY<br><b>Anne Arundel</b>                                                                                                                                             |  | 10c. CITY, TOWN OR LOCATION<br><b>Glen Burnie</b>                                                                                            |                                                                                                       |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                  | 10e. STREET AND NUMBER<br><b>102 N. Charter Road #F</b>                                                                                                                        |  | 10f. ZIP CODE<br><b>21061</b>                                                                                                                |                                                                                                       |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                  | 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |                                                                                                       |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                        |  |                                                                                                                                              |                                                                                                       |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>Construction</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                  | 16. KIND OF BUSINESS/INDUSTRY<br><b>Home Improvement</b>                                                                                                                       |  |                                                                                                                                              |                                                                                                       |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Samuel C. Brown</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ruth Smith</b>                                                                                                         |  |                                                                                                                                              |                                                                                                       |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Ruth Brown</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>102 N. Charter Road #F, Glen Burnie, Md. 21061</b>                         |  |                                                                                                                                              |                                                                                                       |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Holy Cross Cemetery 11/18 Glen Burnie, Md.</b>                                           |  |                                                                                                                                              |                                                                                                       |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Philip Starks</i> <b>MOO550</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                  | 22. NAME AND ADDRESS OF FACILITY<br><b>Sterling Ashton Funeral Home<br/>736 Edmondson Avenue, Catonsville, Md. 21228</b>                                                       |  |                                                                                                                                              |                                                                                                       |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><br>a. <b>COCAINE AND NARCOTIC INTOXICATION</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br><br>d. |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                  |                                                                                                                                                                                |  |                                                                                                                                              | Approximate Interval Between Onset and Death                                                          |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                  |                                                                                                                                                                                |  |                                                                                                                                              | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                  |                                                                                                                                                                                |  |                                                                                                                                              |                                                                                                       |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                  |                                                                                                                                                                                |  |                                                                                                                                              |                                                                                                       |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                               |                                                  |                                                                                                                                                                                |  |                                                                                                                                              |                                                                                                       |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide<br><input checked="" type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                    |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>FOUND: 11-15-94</b>                                                                                                                                                                                                                                                                                                                                                             |                                                  | 28b. TIME OF INJURY<br><b>FOUND: 6:25 A</b>                                                                                                                                    |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                  |                                                                                                       |
| 28d. DESCRIBE NOW INJURY OCCURRED<br><b>UNKNOWN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>FOUND: RESIDENCE</b>                                                                                                                                                                                                                                                                                                            |                                                  |                                                                                                                                                                                |  |                                                                                                                                              |                                                                                                       |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>102 N. CHARTER ROAD<br/>GLEN BURNIE, MD.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                  |                                                                                                                                                                                |  |                                                                                                                                              |                                                                                                       |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Philip Starks</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                  | 29c. LICENSE NUMBER<br><b>O.C.M.E.</b>                                                                                                                                         |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>NOV. 16, 1994</b>                                                                                  |                                                                                                       |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>PHILIP STARKS A. KOREN 111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                  |                                                                                                                                                                                |  |                                                                                                                                              |                                                                                                       |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                  | 32. REGISTRAR'S SIGNATURE<br><i>John A. ...</i>                                                                                                                                |  |                                                                                                                                              |                                                                                                       |

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33872

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                                                       |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
| 1. DECEASED'S NAME (First, Middle, Last)<br><b>James Douglas Bainer</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                     |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov. 14 1994</b>                                                                                                                                       |  | 3. TIME OF DEATH<br><b>4:10 P M</b>                                                         |                                                                                                       |
| 4. SOCIAL SECURITY NUMBER<br><b>275 46 2653</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                          |  | 6. AGE (In yrs. last birthday)<br><b>46</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>9-4-48</b>                                        |                                                                                                       |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Harford Memorial Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                     |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Harford</b>                                                                                                                                           |  | 9c. COUNTY OF DEATH<br><b>Harford</b>                                                       |                                                                                                       |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                     |  | 10b. COUNTY<br><b>Harford Co</b>                                                                                                                                                                |  | 10c. CITY, TOWN OR LOCATION<br><b>Aberdeen</b>                                              |                                                                                                       |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                     |  | 10e. STREET AND NUMBER<br><b>811 Matthews Avenue</b>                                                                                                                                            |  |                                                                                             |                                                                                                       |
| 10f. ZIP CODE<br><b>21001</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                     |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                     |  |                                                                                             |                                                                                                       |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                        |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |                                                                                                       |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (14 or 5+) <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)                                                                                                                                                                          |  | 15b. KIND OF BUSINESS/INDUSTRY                                                                                                                                                                  |  |                                                                                             |                                                                                                       |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Richard Calvin Bainer</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                     |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Helen Lucille Bradely</b>                                                                                                               |  |                                                                                             |                                                                                                       |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs Trudy Bainer</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                     |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>811 Matthews Ave, Aberdeen, MD 21001</b>                                                    |  |                                                                                             |                                                                                                       |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                            |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)                                                                                                                                                                                                     |  | 20c. LOCATION — City or Town, State                                                                                                                                                             |  | 20d. DATE                                                                                   |                                                                                                       |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Ronald Wade, Dir</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                     |  | 22. NAME AND ADDRESS OF FACILITY<br><b>State Anatomy Board<br/>655W. Baltimore St, Balto, MD 21201</b>                                                                                          |  |                                                                                             |                                                                                                       |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Hypertension and Atherosclerotic Cardiovascular Disease</b><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                             | Approximate Interval Between Onset and Death                                                          |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                             | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                                                       |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                                                       |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                                                       |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                       |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                              |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |                                                                                                       |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                     |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                          |  |                                                                                             |                                                                                                       |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                     |  | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                    |  |                                                                                             |                                                                                                       |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                                                       |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Richard J. Colfer, M.D., Harford County</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                     |  | 29c. LICENSE NUMBER<br><b>OCME</b>                                                                                                                                                              |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/14/94</b>                                      |                                                                                                       |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>RICHARD J. COLFER, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                     |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>2013 TRAPPE CHURCH ROAD<br/>DARLINGTON, MARYLAND 21034</b>                                            |  |                                                                                             |                                                                                                       |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 32. REGISTRAR'S SIGNATURE<br><b>John A. ...</b>                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                                                       |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33873

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                         |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Harold A. Boss</b>                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov. 17, 1994</b>                                                                                                                                      |  | 3. TIME OF DEATH<br><b>5:15 P. M.</b>                                                                                                   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>227-07-0590</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>82</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Dec. 6, 1911</b>                                                                              |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>University Hospital</b>                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>                                                                                                                                         |  | 9c. COUNTY OF DEATH                                                                                                                     |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                         |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                |  | 10b. COUNTY                                                                                                                                                                                                                                                                                    |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                                                                                                                                                 |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                         |  |
| 10e. STREET AND NUMBER<br><b>407 N. Chapel Gate Lane</b>                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  | 10f. ZIP CODE<br><b>21229</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                          |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                               |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                 |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>                                                                                                                                                                                                                                                                                         |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Purchasing Agent</b>                                                                                                                                                          |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Manufacturing</b>                                                                                                                                          |  |                                                                                                                                         |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Boland Gibbs Boss Sr.</b>                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Gertrude Barnes</b>                                                                                                                     |  |                                                                                                                                         |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Dr. Betsy Singh (Daughter)</b>                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>407 N. Chapel Gate Lane Baltimore Maryland 21229</b>                                        |  |                                                                                                                                         |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metro Crematory 11-18-94</b>                                                                                                                                                                             |  | 20c. LOCATION — City or Town, State<br><b>Catonsville Maryland</b>                                                                                                                              |  |                                                                                                                                         |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Leroy M &amp; Russell C Witzke Jr</i>                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Leroy M &amp; Russell C Witzke Funeral Homes<br/>1630 Edmondson Avenue Catonsville Maryland</b>                                                          |  |                                                                                                                                         |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                         |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Chronic Subdural Hematoma</b>                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                         |  |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                         |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                         |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                         |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                         |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Normal Pressure Hydrocephalus</b>                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                         |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                         |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                       |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                                                         |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                   |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                        |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                          |  |                                                                                                                                         |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                         |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                         |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>B. Bern MD</i>                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>023707</b>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/17/94</b>                                                                                  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>UMMS Family Medicine</b>                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                         |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  | 32. REGISTRAR'S SIGNATURE<br><i>John Anderson-Rodell</i>                                                                                                                                        |  |                                                                                                                                         |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This certificate requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 29 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





94 33874

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                  |                                                                                                           |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>MILDRED A. BENISHEK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                              |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>NOV 7 1994                                                                                                                                                                                                                                                                                                                                                                                 |  | 3. TIME OF DEATH<br>12:50 A M                                                                                                                    |                                                                                                           |
| 4. SOCIAL SECURITY NUMBER<br>342-20-3527                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                               |  | 6. AGE (In yrs. last birthday)<br>82 YRS.                                                                                                                                                                                                                                                                                                                                                                                        |  | 7. DATE OF BIRTH (Month, Day, Year)<br>JAN 12, 1912                                                                                              |                                                                                                           |
| 8. BIRTHPLACE (State or Foreign Country)<br>IOWA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                              |  | 9a. FACILITY NAME (If not institution, give street and number)<br>HOWARD COUNTY GENERAL HOSPITAL                                                                                                                                                                                                                                                                                                                                 |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>COLUMBIA                                                                                                  |                                                                                                           |
| 9c. COUNTY OF DEATH<br>HOWARD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                              |  | 10a. STATE<br>MD                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 10b. COUNTY<br>HOWARD                                                                                                                            |                                                                                                           |
| 10c. CITY, TOWN OR LOCATION<br>COLUMBIA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                              |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                              |  | 10e. STREET AND NUMBER<br>6336 CEDAR LANE                                                                                                        |                                                                                                           |
| 10f. ZIP CODE<br>21044                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                                                                                                                                                                         |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                           |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |                                                                                                           |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                              |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>WHITE                                                                                                                                                                                                                                                                                                                                                              |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 8+) NONE                       |                                                                                                           |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>RESTAURANT MANAGER                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                              |  | 16b. KIND OF BUSINESS/INDUSTRY<br>FOOD SERVICE                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                  |                                                                                                           |
| 17. FATHER'S NAME (First, Middle, Last)<br>DAVID PAYNE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                              |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>ROSE ETTA JOHNSON                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                  |                                                                                                           |
| 19a. INFORMANT'S NAME (Type/Print)<br>STEPHEN L. BENISHEK (SON)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                              |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>704 203rd STREET, PASADENA, MD 21122                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                  |                                                                                                           |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>METRO CREMATORY NOV 9, 1994                                                                                                                                                                               |  | 20c. LOCATION — City or Town, State<br>CATONSVILLE, MD                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                  |                                                                                                           |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                              |  | 22. NAME AND ADDRESS OF FACILITY<br>LEROY M & RUSSELL C WITZKE FUNERAL HOME<br>5555 TWIN KNOLLS RD. COLUMBIA, MD 21045                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                  |                                                                                                           |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Failure<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                  | Approximate Interval Between Onset and Death                                                              |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                  |                                                                                                           |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                  |                                                                                                           |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                            |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                       |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                            |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                             |                                                                                                           |
| 28d. DESCRIBE NOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                              |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                  |                                                                                                           |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                              |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                  |                                                                                                           |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>William Flowers MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                              |  | 29c. LICENSE NUMBER<br>D20708                                                                                                                                                                                                                                                                                                                                                                                                    |  | 29d. DATE SIGNED (Month, Day, Year)<br>11/17/94                                                                                                  |                                                                                                           |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>William Flowers MD 11055 Little Belvoir Pkwy Columbia MD                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                  |                                                                                                           |
| 31. DATE FILLED (Month, Day, Year)<br>NOV 18 1994                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                              |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                  |                                                                                                           |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>EVELYN BOONE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>09</b> YEAR <b>94</b>                                                                                                                                |  | 3. TIME OF DEATH<br><b>11:20 A M</b>                                                                                                                                           |  |
| 4. SOCIAL SECURITY NUMBER<br><b>219-40-2617</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>51</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>02-24-43</b>                                                                                                                         |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Virginia</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Liberty Medical</b>                                                                                                        |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>                                                                                                                        |  |
| 9c. COUNTY OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  | 10a. STATE<br><b>Maryland</b>                                                                                                                                                                   |  | 10b. COUNTY<br><b>Baltimore</b>                                                                                                                                                |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                 |  | 10e. STREET AND NUMBER<br><b>4011 Fairview Road</b>                                                                                                                            |  |
| 10f. ZIP CODE<br><b>21216</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                     |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                                                                                                        |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>High School</b> College (1-4 or 5+) <b>College</b>                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife</b>                                                                  |  | 16b. KIND OF BUSINESS/INDUSTRY                                                                                                                                                 |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William Wise Sr.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary Harper</b>                                                                                                                         |  |                                                                                                                                                                                |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Evelyn R. Boone Jean Frazier</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1622 Gwynns Falls Parkway Baltimore, Md. 21216</b>                                          |  |                                                                                                                                                                                |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Arbutus Memorial Park 11/14</b>                                                                           |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Maryland</b>                                                                                                              |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Kevin Parker</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Nutter Funeral Home Inc. 2501 Gwynn Falls PKY. Balt. MD. 21216</b>                                                                                       |  |                                                                                                                                                                                |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>SEPSIS</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>METASTATIC CARCINOMA BREAST</b><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>HYPERCALCEMIA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                           |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                    |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                         |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                    |  |                                                                                                                                                                                |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>MD. D 23300</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER                                                                                                                                                                             |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11.9.94</b>                                                                                                                          |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>SUDHIR D. PATEL 2600 Liberty Medical Center Baltimore MD.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  | 32. REGISTRAR'S SIGNATURE<br><b>21215</b>                                                                                                                                                       |  |                                                                                                                                                                                |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MILBURN BOYER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                           |  | 2. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>10</b> YEAR <b>94</b>                                                                                                                                |  | 3. TIME OF DEATH<br><b>7 P M</b>                                                                |                                                                                                       |
| 4. SOCIAL SECURITY NUMBER<br><b>215-28-1262</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                                |  | 6. AGE (In yrs. last birthday)<br><b>65</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>August 31, 1929</b>                                   |                                                                                                       |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                           |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>3004 Grantly Avenue</b>                                                                                                    |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>                                         |                                                                                                       |
| 9c. COUNTY OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 10b. COUNTY                                                                                                                                                                                                                                                                                               |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                                                                                                                                                 |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |                                                                                                       |
| 10e. STREET AND NUMBER<br><b>3004 Grantly Avenue</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                           |  | 10f. ZIP CODE<br><b>21215</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                     |                                                                                                       |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                              |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                         |                                                                                                       |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th grade</b><br>College (1-4 or 5+) <b>College</b>                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Assistant Manager Operations Baltimore Public Schools</b>                                                                                                                                |  | 16b. KIND OF BUSINESS/INDUSTRY                                                                                                                                                                  |  |                                                                                                 |                                                                                                       |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Charles Boyer</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                           |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Georgianna Nash</b>                                                                                                                     |  |                                                                                                 |                                                                                                       |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Geraldine Boyer</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                           |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3004 Grantly Avenue Baltimore, Maryland 21215</b>                                           |  |                                                                                                 |                                                                                                       |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                         |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Druid Ridge</b>                                                                                                                                                                                                     |  | DATE <b>11/15</b>                                                                                                                                                                               |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Maryland</b>                               |                                                                                                       |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Herbert E. Nutter</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                           |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Nutter Funeral Homes, Inc<br/>2501 /Gwynns Falls Parkway<br/>Baltimore, Maryland 21216</b>                                                               |  |                                                                                                 |                                                                                                       |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Lung Cancer</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                 |  |                                                                                                 | Approximate Interval Between Onset and Death                                                          |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                 |  |                                                                                                 | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                    |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                    |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |                                                                                                       |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                           |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                               |  |                                                                                                 |                                                                                                       |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Robert Gorbatsky MD</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                           |  | 29c. LICENSE NUMBER<br><b>027938</b>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/11/94</b>                                          |                                                                                                       |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Mayer Gorbatsky M.D. 795 Aqueduct Rd. Glen Burnie, MD 21061</b>                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                           |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Anderson-Robert</i>                                                                                                                                       |  |                                                                                                 |                                                                                                       |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33877

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                    |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Chester Thomas Black</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>16</b> YEAR <b>94</b>                                                                                                                                |  | 3. TIME OF DEATH<br><b>0515 A</b>                                                               |                                                                                                                                                    |
| 4. SOCIAL SECURITY NUMBER<br><b>215-36-7098</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>90</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>09/05/04</b>                                          |                                                                                                                                                    |
| 8a. FACILITY NAME (If not institution, give street and number)<br><b>Frederick Memorial Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br><b>Frderick</b>                                                                                                                                          |  | 8c. COUNTY OF DEATH<br><b>Frederick</b>                                                         |                                                                                                                                                    |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                    |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 10b. COUNTY<br><b>Carroll</b>                                                                                                                                                                                                                                                                  |  | 10c. CITY, TOWN OR LOCATION<br><b>New Windsor</b>                                                                                                                                               |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |                                                                                                                                                    |
| 10e. STREET AND NUMBER<br><b>14817 Barnes Road</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  | 10f. ZIP CODE<br><b>21776</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                  |                                                                                                                                                    |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |                                                                                                                                                    |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>Grade School (years unknown)</b><br>College (1-4 or 5+) <b>College (years unknown)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Self Employed</b>                                                                                                                                                          |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Farmer</b>                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                    |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Charles Black</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Marian Bart</b>                                                                                                                         |  |                                                                                                 |                                                                                                                                                    |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs. Beulah Black</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>14817 Barnes Road New Windsor, MD 21776</b>                                                 |  |                                                                                                 |                                                                                                                                                    |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                    |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Linganore Cemetery</b>                                                                                                                                                                                   |  | DATE<br><b>11/19/94</b>                                                                                                                                                                         |  | 20c. LOCATION — City or Town, State<br><b>Unionville, Maryland</b>                              |                                                                                                                                                    |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Burrier-Queen Funeral Directors, P.A.<br/>1212 W. Old Liberty Road Winfield, MD 21784</b>                                                                |  |                                                                                                 |                                                                                                                                                    |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute myocardial infarction</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 | Approximate Interval Between Onset and Death                                                                                                       |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Renal Failure</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                    |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                            |  | 25a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 25b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 25c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |                                                                                                                                                    |
| 25d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  | 25e. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                               |  |                                                                                                 |                                                                                                                                                    |
| 25f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                    |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                    |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>030721</b>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/16/94</b>                                          |                                                                                                                                                    |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Debra H. Cline MD 316 W. 4th St. P.O. Box 140 2174</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                    |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                   |  |                                                                                                 |                                                                                                                                                    |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

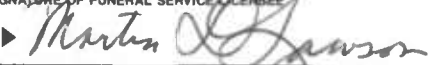





94 33878

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                               |  |                                                                                             |                                                                                                       |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JOHN Henry BENHOFF III</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov 18 1994</b>                                                                                                                                      |  | 3. TIME OF DEATH<br><b>2:30 am</b>                                                          |                                                                                                       |
| 4. SOCIAL SECURITY NUMBER<br><b>215-07-1277</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>79</b> YRS.                                                                                                                                              |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Sept. 4, 1915</b>                                 |                                                                                                       |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Balto. Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Saint Joseph Hospital</b>                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Towson, Maryland</b>                              |                                                                                                       |
| 9c. COUNTY OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  | 10a. STATE<br><b>Maryland</b>                                                                                                                                                                 |  | 10b. COUNTY<br><b>Baltimore Co.</b>                                                         |                                                                                                       |
| 10c. CITY, TOWN OR LOCATION<br><b>Towson</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                               |  | 10e. STREET AND NUMBER<br><b>7012 York Road</b>                                             |                                                                                                       |
| 10f. ZIP CODE<br><b>21212</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                   |  |                                                                                             |                                                                                                       |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                               |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |                                                                                                       |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>mechanical engineer</b>                                                                                                                                                       |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Exxon Oil Co.</b>                                                                                                                                        |  |                                                                                             |                                                                                                       |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John Henry Benhoff, Jr.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ella Mae Kirkwood</b>                                                                                                                 |  |                                                                                             |                                                                                                       |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>John R. Hough</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>W. Palm Bh. 2001 Palm Beach Lakes Blvd. #200 F la. 33409</b>                              |  |                                                                                             |                                                                                                       |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                        |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Greenmount Crematory 11/19/94 Balto. Md.</b>                                                                                                                                                             |  | 20c. LOCATION — City or Town, State                                                                                                                                                           |  |                                                                                             |                                                                                                       |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Mitchell-Wiedefeld Home, Inc. 6500 York Road, Balto. Md. 21212</b>                                                                                     |  |                                                                                             |                                                                                                       |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>s. RENAL FAILURE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                               |  |                                                                                             | Approximate Interval Between Onset and Death<br><b>1 WEEK</b>                                         |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>SEPSIS / ATRIAL FIBRILLATION</b><br><b>PERIPHERAL VASCULAR DISEASE</b><br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                               |  |                                                                                             | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                               |  |                                                                                             |                                                                                                       |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                               |  |                                                                                             |                                                                                                       |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                    |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                               |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |                                                                                                       |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                        |  |                                                                                             |                                                                                                       |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                               |  |                                                                                             |                                                                                                       |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                               |  |                                                                                             |                                                                                                       |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Joginder P Mehta M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>D 41410</b>                                                                                                                                                         |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11-18-94</b>                                      |                                                                                                       |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>JOGINDER P. MEHTA, MD ST. JOSEPH MEDICAL CENTER TOWSON, MD 21204</b>                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                               |  |                                                                                             |                                                                                                       |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  | 32. REGISTRAR'S SIGNATURE<br>                                                                              |  |                                                                                             |                                                                                                       |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Item#19b Per F.H. Film# G-717 11/18/94 R.M.

1 -  
FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                |  |                                                                                                                                                    |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>TIMOTHY JOHN BENNETT</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                               |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOV. 16, 1994</b>                                                                                                                                     |  | 3. TIME OF DEATH<br><b>11:37 P M</b>                                                                                                               |  |
| 4. SOCIAL SECURITY NUMBER<br><b>020-54-9643</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                                    |  | 6. AGE (In yrs. last birthday)<br><b>32</b> YRS.                                                                                                                                               |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>March 3, 1962</b>                                                                                        |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>1930 MARRIOTT COURTYARD RM. 715</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                               |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Montgomery</b>                                                                                                                                       |  | 9c. COUNTY OF DEATH<br><b>Massachusetts</b>                                                                                                        |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                |  |                                                                                                                                                    |  |
| 10a. STATE<br><b>New York</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 10b. COUNTY<br><b>Tioga</b>                                                                                                                                                                                                                                                                                   |  | 10c. CITY, TOWN OR LOCATION<br><b>Endicott</b>                                                                                                                                                 |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                    |  |
| 10e. STREET AND NUMBER<br><b>9 Parmerton Drive</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                               |  | 10f. ZIP CODE<br><b>13760</b>                                                                                                                                                                  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                        |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>white</b>                                                                            |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>6</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Optical Engineer</b>                                                                                                                                                                         |  | 18b. KIND OF BUSINESS/INDUSTRY<br><b>Loral Federal System</b>                                                                                                                                  |  |                                                                                                                                                    |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William J. Bennett</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                               |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary L. Morrison</b>                                                                                                                   |  |                                                                                                                                                    |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Theresa Bennett</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                               |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9 Parmerton Dr., Crestview Hts., Endicott. N.Y. 13760</b>                                  |  |                                                                                                                                                    |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                           |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Calvary Cemetery 11/21</b>                                                                                                                                                                                              |  | 20c. LOCATION — City or Town, State<br><b>Johnson City, New York</b>                                                                                                                           |  |                                                                                                                                                    |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Gary L. Kaufman</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                               |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Gary L. Kaufman Funeral Home of Elk., Inc.<br/>5695 Main St., Elkridge, Md. 21227</b>                                                                   |  |                                                                                                                                                    |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ASPHYXIA</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br><br>d. |  |                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                |  | Approximate Interval Between Onset and Death                                                                                                       |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                              |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 28. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>HOTEL ROOM</b> |  |                                                                                                                                                                                                |  |                                                                                                                                                    |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                   |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>UNK</b>                                                                                                                                                                                                                                                          |  | 28b. TIME OF INJURY<br><b>UNK</b> M                                                                                                                                                            |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>HOTEL</b>                                                                                                                                                                                                        |  | 28e. DESCRIBE HOW INJURY OCCURRED<br><b>Placed plastic bag over head and the around neck</b>                                                                                                   |  |                                                                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>1930 Marriott Courtyard # 715</b>                                                                                                                                                                                          |  |                                                                                                                                                                                                |  |                                                                                                                                                    |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                |  |                                                                                                                                                    |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John Locke MD</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                               |  | 29c. LICENSE NUMBER<br><b>OCME</b>                                                                                                                                                             |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>NOV. 17, 1994</b>                                                                                        |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>John Locke, MD 111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                |  |                                                                                                                                                    |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                               |  | 32. REGISTRAR'S SIGNATURE<br><i>John Locke</i>                                                                                                                                                 |  |                                                                                                                                                    |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                               |  |                                                                                             |                                                                                                       |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>John Wesley Botts                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>Nov. 16, 1994                                                                                                                                           |  | 3. TIME OF DEATH<br>3:25p M                                                                 |                                                                                                       |
| 4. SOCIAL SECURITY NUMBER<br>216-09-4860                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br>86 YRS.                                                                                                                                                     |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Jan. 28, 1908                                     |                                                                                                       |
| 9a. FACILITY NAME (If not institution, give street and number)<br>North Arundel Hospital                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Glen Burnie                                                                                                                                            |  | 9c. COUNTY OF DEATH<br>Anne Arundel                                                         |                                                                                                       |
| 10a. STATE<br>Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  | 10b. COUNTY<br>Anne Arundel                                                                                                                                                                   |  | 10c. CITY, TOWN OR LOCATION<br>Odenton                                                      |                                                                                                       |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  | 10e. STREET AND NUMBER<br>448 Patuxent Rd.                                                                                                                                                    |  |                                                                                             |                                                                                                       |
| 10f. ZIP CODE<br>21113                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                                                                          |  |                                                                                             |                                                                                                       |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                         |                                                                                                       |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 08 College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Security Officer                                                                                                                                                              |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Plastics Plant                                                                                                                                              |  |                                                                                             |                                                                                                       |
| 17. FATHER'S NAME (First, Middle, Last)<br>Michael C. Botts                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Alice Rollings                                                                                                                           |  |                                                                                             |                                                                                                       |
| 19a. INFORMANT'S NAME (Type/Print)<br>Viola R. Westlake                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>268 Dover Rd Warrenton, Virginia 22186                                                       |  |                                                                                             |                                                                                                       |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                             |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Stonewall Memorial Gardens 11/21                                                                                                                                                                            |  | 20c. LOCATION — City or Town, State<br>Manassass, VA                                                                                                                                          |  |                                                                                             |                                                                                                       |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Patrick J. Arnold</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br>Hardesty Funeral Home, PA 21054<br>851 Annapolis Rd. Gambrills Md.                                                                                        |  |                                                                                             |                                                                                                       |
| 23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Myocardial Infarction</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <i>Chronic obstructive lung disease</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                               |  |                                                                                             | Approximate Interval Between Onset and Death                                                          |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Pneumonia</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                               |  |                                                                                             | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                               |  |                                                                                             |                                                                                                       |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                               |  |                                                                                             |                                                                                                       |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                               |  |                                                                                             |                                                                                                       |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                         |  | 28a. DATE OF INJURY<br>(Month, Day, Year)                                                                                                                                                                                                                                                      |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                      |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |                                                                                                       |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                         |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                  |  |                                                                                             |                                                                                                       |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                               |  |                                                                                             |                                                                                                       |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Marjorie Sichelberger</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br>D42146                                                                                                                                                                 |  | 29d. DATE SIGNED (Month, Day, Year)<br>11/17/94                                             |                                                                                                       |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>1215 Annapolis Rd. Suite 107 Odenton, MD 21113                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                               |  |                                                                                             |                                                                                                       |
| 31. DATE FILED (Month, Day, Year)<br>NOV 18 1994                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  | 32. REGISTRAR'S SIGNATURE<br><i>John Andrew Harrell</i>                                                                                                                                       |  |                                                                                             |                                                                                                       |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33881

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                                        |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Anna Barth</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>Nov. 13 1994</i>                                                                                                                                           |  | 3. TIME OF DEATH<br><i>12:00a.m.</i>                                                                |                                                                                                                                                        |
| 4. SOCIAL SECURITY NUMBER<br><i>NONE</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                             |  | 6. AGE (In yrs. last birthday)<br>YRS. MONTHS DAYS<br><i>2 2</i>                                                                                                                                    |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>Nov. 11, 1994</i>                                      |                                                                                                                                                        |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>University Maryland Medical System</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Baltimore, Maryland</i>                                                                                                                                   |  | 9c. COUNTY OF DEATH<br><i>Baltimore City</i>                                                        |                                                                                                                                                        |
| 10a. STATE<br><i>Maryland</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 10b. COUNTY<br><i>Dorchester</i>                                                                                                                                                                                                                                                                           |  | 10c. CITY, TOWN OR LOCATION<br><i>Fishing Creek</i>                                                                                                                                                 |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |                                                                                                                                                        |
| 10e. STREET AND NUMBER<br><i>2642 Nooper's Island Road</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                            |  | 10f. ZIP CODE<br><i>21634</i>                                                                                                                                                                       |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>                                                         |                                                                                                                                                        |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                           |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>white</i>                             |                                                                                                                                                        |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>D</i> College (1-4 or 5+) <i>None</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>None</i>                                                                                                                                                                               |  | 16b. KIND OF BUSINESS/INDUSTRY                                                                                                                                                                      |  |                                                                                                     |                                                                                                                                                        |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Joseph Barth</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Wendy Barth DETTMER</i>                                                                                                                     |  |                                                                                                     |                                                                                                                                                        |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>REV. JOSEPH BARTH</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>2642 Hooper's Island Road, Fishing Creek, Maryland</i>                                          |  |                                                                                                     |                                                                                                                                                        |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>PENNSVILLE CEMETERY 11/18/94</i>                                                                                                                                                                                     |  | 20c. LOCATION — City or Town, State<br><i>LEHIGH TOWNSHIP, PA.</i>                                                                                                                                  |  |                                                                                                     |                                                                                                                                                        |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Philip Staley J.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br><i>STALLINGS FUNERAL HOME<br/>3111 MOUNTAIN ROAD, PASADENA MD. 21122</i>                                                                                        |  |                                                                                                     |                                                                                                                                                        |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Respiratory Distress Syndrome</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><i>b. Extreme Prematurity</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><i>c.</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><i>d.</i><br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     | Approximate interval Between Onset and Death                                                                                                           |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Patent Ductus Arteriosus, Pulmonary Interstitial Emphysema, Severe Intraventricular Hemorrhage</i>                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                         |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                                        |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                        |  | 28a. DATE OF INJURY<br>(Month, Day, Year)                                                                                                                                                                                                                                                                  |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                               |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |                                                                                                                                                        |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                     |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                        |  |                                                                                                     |                                                                                                                                                        |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                                        |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Lillian R. Blackmon, M.D.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  | 29c. LICENSE NUMBER<br><i>MD 026066</i>                                                                                                                                                             |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>Nov. 14, 1994</i>                                         |                                                                                                                                                        |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Lillian R. Blackmon, M.D.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                                        |
| 31. DATE FILED (Month, Day, Year)<br><i>NOV 18 1994</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |  | 32. REGISTRAR'S SIGNATURE<br><i>John Andrew...</i>                                                                                                                                                  |  |                                                                                                     |                                                                                                                                                        |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





94 33882

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                              |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                                                                                                    |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Benjamin Michael Barth</i>                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                              |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>November 16 1994</i>                                                                                                                                   |  | 3. TIME OF DEATH<br><i>6:57p M</i>                                                          |                                                                                                                                                    |
| 4. SOCIAL SECURITY NUMBER<br><i>NONE</i>                                                                                                                                                                                                                                                                                                                                                                                     |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                   |  | 6. AGE (In yrs. last birthday)<br>YRS. MONTHS DAYS<br><i>5</i>                                                                                                                                  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>Nov. 11, 1994</i>                              |                                                                                                                                                    |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>University of Maryland Medical System</i>                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                              |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Baltimore, Maryland</i>                                                                                                                               |  | 9c. COUNTY OF DEATH<br><i>Baltimore City</i>                                                |                                                                                                                                                    |
| 10a. STATE<br><i>Maryland</i>                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                              |  | 10b. COUNTY<br><i>Dorchester</i>                                                                                                                                                                |  | 10c. CITY, TOWN OR LOCATION<br><i>Fishing Creek, Maryland</i>                               |                                                                                                                                                    |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                              |  | 10e. STREET AND NUMBER<br><i>2642 HOOPER'S ISLAND ROAD</i>                                                                                                                                      |  |                                                                                             |                                                                                                                                                    |
| 10f. ZIP CODE<br><i>21634</i>                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                              |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>                                                                                                                                                     |  |                                                                                             |                                                                                                                                                    |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                               |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>white</i>                     |                                                                                                                                                    |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>0</i> College (1-4 or 5+) <i></i>                                                                                                                                                                                                                                                                                       |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>None</i>                 |  | 16b. KIND OF BUSINESS/INDUSTRY                                                                                                                                                                  |  |                                                                                             |                                                                                                                                                    |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Joseph Barth</i>                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                              |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Wendy Barth DETTMER</i>                                                                                                                 |  |                                                                                             |                                                                                                                                                    |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>REV. JOSEPH BARTH</i>                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                              |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>2642 HOOPER'S ISLAND ROAD, FISHING CREEK, MD 21634</i>                                      |  |                                                                                             |                                                                                                                                                    |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>PENNSVILLE CEMETERY</i>                                |  | 20c. DATE<br><i>11/18/94</i>                                                                                                                                                                    |  | 20d. LOCATION — City or Town, State<br><i>LEHIGH TOWNSHIP, PA</i>                           |                                                                                                                                                    |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                              |  | 22. NAME AND ADDRESS OF FACILITY<br><i>STALLINGS FUNERAL HOME, P.A.<br/>3111 MOUNTAIN ROAD, PASADENA, MD 21122</i>                                                                              |  |                                                                                             |                                                                                                                                                    |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Severe Respiratory Distress Syndrome</i><br>DUE TO (OR AS A CONSEQUENCE OF):                                                               |  |                                                                                                                                              |  |                                                                                                                                                                                                 |  |                                                                                             | Approximate Interval Between Onset and Death<br><i>5</i>                                                                                           |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                   |  |                                                                                                                                              |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                                                                                                    |
| b. DUE TO (OR AS A CONSEQUENCE OF): <i>Multiple Gestation, Triplet</i>                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                              |  |                                                                                                                                                                                                 |  |                                                                                             | <i>5</i>                                                                                                                                           |
| c. DUE TO (OR AS A CONSEQUENCE OF): <i>Extreme Prematurity</i>                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                              |  |                                                                                                                                                                                                 |  |                                                                                             | <i>5</i>                                                                                                                                           |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Patent Ductus Arteriosus, Cardiogenic Shock<br/>Intraventricular Hemorrhage</i>                                                                                                                                                                                                                 |  |                                                                                                                                              |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                                                                                                    |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                              |  |                                                                                                                                                                                                 |  |                                                                                             | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                              |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                                                                                                    |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                               |  |                                                                                                                                              |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                                                                                                    |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined                                                                                                                                                   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)                                                                                                    |  | 28b. TIME OF INJURY<br><i>M</i>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |                                                                                                                                                    |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                              |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                          |  |                                                                                             |                                                                                                                                                    |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                              |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                                                                                                    |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                              |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                                                                                                    |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Lillian R. Blackmon, M.D.</i>                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                              |  | 29c. LICENSE NUMBER<br><i>MD 026066</i>                                                                                                                                                         |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>Nov. 16, 1994</i>                                 |                                                                                                                                                    |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Lillian R. Blackmon M.D.</i>                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                              |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                                                                                                    |
| 31. DATE FILED (Month, Day, Year)<br><i>NOV 18 1994</i>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                              |  | 32. REGISTRAR SIGNATURE<br><i>[Signature]</i>                                                                                                                                                   |  |                                                                                             |                                                                                                                                                    |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                 |  |                                                                                                                                                    |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Wendy Barth</i>                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                   |  | 2. DATE OF DEATH<br>MONTH <i>11</i> DAY <i>13</i> YEAR <i>1994</i>                                                                                                                              |  | 3. TIME OF DEATH<br><i>1453</i> M                                                                                                                  |  |
| 4. SOCIAL SECURITY NUMBER<br><i>187-62-8918</i>                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                        |  | 6. AGE (In yrs. last birthday)<br><i>28</i> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><i>07/29/66</i>                                                                                             |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>UNIVERSITY OF MARYLAND MEDICAL SYSTEM</i>                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>BALTIMORE, MARYLAND</i>                                                                                                                               |  | 9c. COUNTY OF DEATH<br><i>BALTIMORE CITY</i>                                                                                                       |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                 |  |                                                                                                                                                    |  |
| 10a. STATE<br><i>MARYLAND</i>                                                                                                                                                                                                                                                                                                                                                                                                |  | 10b. COUNTY<br><i>DORCHESTER</i>                                                                                                                                                                                                                                                                  |  | 10c. CITY, TOWN OR LOCATION<br><i>FISHING CREEK</i>                                                                                                                                             |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                    |  |
| 10e. STREET AND NUMBER<br><i>2642 HOOPER'S ISLAND ROAD</i>                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                   |  | 10f. ZIP CODE<br><i>21634</i>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>                                                                                                     |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                               |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                      |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><i>WHITE</i>                                                                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12</i><br>College (1-4 or 5+) <i>College</i>                                                                                                                                                                                                                                                                            |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>HOMEMAKER</i>                                                                                                                                                                 |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>HOUSEHOLD</i>                                                                                                                                              |  |                                                                                                                                                    |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>RUSSELL D. DETIMER</i>                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>CHERYL L. (JONES)</i>                                                                                                                   |  |                                                                                                                                                    |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>REV. JOSEPH BARTH</i>                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>2642 HOOPER'S ISLAND RD., FISHING CREEK, MD. 21634</i>                                      |  |                                                                                                                                                    |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                             |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>PENNSVILLE CEMETERY</i> <i>11/18/94</i>                                                                                                                                                                     |  | 20c. LOCATION — City or Town, State<br><i>LEHIGH TOWNSHIP, PA.</i>                                                                                                                              |  |                                                                                                                                                    |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                   |  | 22. NAME AND ADDRESS OF FACILITY<br><i>STALLINGS FUNERAL HOME</i><br><i>3111 MOUNTAIN ROAD, PASADENA MD. 21122</i>                                                                              |  |                                                                                                                                                    |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                 |  |                                                                                                                                                    |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →                                                                                                                                                                                                                                                                                                                                                            |  | <p style="text-align: center;"><i>GENERALIZED SEPTICEMIA</i></p> <p>a. <i>Possible pulmonary embolus</i><br/>DUE TO (OR AS A CONSEQUENCE OF):</p> <p>b. <i>Pregnancy</i><br/>DUE TO (OR AS A CONSEQUENCE OF):</p> <p>c. <i>Marbled obesity</i><br/>DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d.</p> |  |                                                                                                                                                                                                 |  |                                                                                                                                                    |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                 |  |                                                                                                                                                    |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                 |  |                                                                                                                                                    |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                           |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)    |  |                                                                                                                                                                                                 |  |                                                                                                                                                    |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined                                                                                                                                                   |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                            |  | 28b. TIME OF INJURY<br><i>M</i>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 28d. DESCRIBE HOW INJURY OCCURED                                                                                                                                                                                                                                                                  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                          |  |                                                                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                      |  |                                                                                                                                                                                                 |  |                                                                                                                                                    |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                 |  |                                                                                                                                                    |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i> M.D.                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                   |  | 29c. LICENSE NUMBER<br><i>D35702</i>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>11/14/94</i>                                                                                             |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Mary L. Johnson Univ. of MD</i> <i>22 S. Green St 21201</i>                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                 |  |                                                                                                                                                    |  |
| 31. DATE FILED (Month, Day, Year)<br><i>NOV 1 8 1994</i>                                                                                                                                                                                                                                                                                                                                                                     |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                 |  |                                                                                                                                                    |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33884

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                  |                                                                                                       |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>WILLIAM EDWARD BACON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>8</b> YEAR <b>94</b>                                                                                                                                                                                                                                                                                                                                                                 |  | 3. TIME OF DEATH<br><b>9:45A</b> M                                               |                                                                                                       |
| 4. SOCIAL SECURITY NUMBER<br><b>216 07 6607</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>92</b> YRS.                                                                                                                                                                                                                                                                                                                                                                                |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>6-11-1902</b>                       |                                                                                                       |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  | 9. FACILITY NAME (If not institution, give street and number)<br><b>2200 Wheatley Drive #101</b>                                                                                                                                                                                                                                                                                                                                |  |                                                                                  |                                                                                                       |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  | 10b. COUNTY<br><b>na</b>                                                                                                                                                                                                                                                                                                                                                                                                        |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                                  |                                                                                                       |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  | 10e. STREET AND NUMBER<br><b>2200 Wheatley Drive #101</b>                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                  |                                                                                                       |
| 10f. ZIP CODE<br><b>21207</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                  |                                                                                                       |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>1945</b>                                                                                                                                            |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input type="checkbox"/> NO Specify:                                                                                                                                                                                                                                            |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>          |                                                                                                       |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)                                                                                                                                                                                                                                                                                                                   |  | 16b. KIND OF BUSINESS/INDUSTRY                                                   |                                                                                                       |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William Edward Bacon</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary Smith</b>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                  |                                                                                                       |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Rodella Kendall</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2200 Wheatley Drive #101, Balto, MD 21207</b>                                                                                                                                                                                                                                                                               |  |                                                                                  |                                                                                                       |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)                                                                                                                                                                                                                                                                                                                                                 |  | 20c. LOCATION — City or Town, State                                              |                                                                                                       |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Ronald Wade, Dir</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>State Anatomy Board<br/>655W. Baltimore St, Balto, MD 21201</b>                                                                                                                                                                                                                                                                                                                          |  |                                                                                  |                                                                                                       |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Probable Aspiration</b><br><b>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br><b>Carcinoma of Pancreas</b><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br><b>Generalized Arteriosclerosis</b><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                  | Approximate Interval Between Onset and Death                                                          |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Multiple Cerebral Infarction</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                  |                                                                                                       |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                  |                                                                                                       |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 28a. DATE OF INJURY<br>(Month, Day, Year)                                                                                                                                                                                                                                                      |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                                                                                                                                                                                                                                                        |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |                                                                                                       |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                          |  |                                                                                  |                                                                                                       |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  | 29a. CERTIFIER<br>(Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                  |                                                                                                       |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Dr. Abousy</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>D12729</b>                                                                                                                                                                                                                                                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/10/94</b>                           |                                                                                                       |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DR. ABOUSY 2300 Garrison Blvd, Balto, MD 21216</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                  |                                                                                                       |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  | 32. REGISTRAR'S SIGNATURE<br><i>Jane Shuler Kendall</i>                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                  |                                                                                                       |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33885

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                          |  |                                                                                      |                                                                                                           |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MARSHALL C. Marshall BROWN Brown</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  | 2. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>12</b> YEAR <b>1994</b>                                                                                                                       |  | 3. TIME OF DEATH<br><b>12 noon</b>                                                   |                                                                                                           |
| 4. SOCIAL SECURITY NUMBER<br><b>228 12 1535</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                                                                                                                                                             |  | 6. AGE (in yrs. last birthday)<br><b>79</b> YRS.                                                                                                                                         |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>12-25-1914</b>                             |                                                                                                           |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Medlantic Manor at Layhill</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Silver Spring</b>                                                                                                                              |  | 9c. COUNTY OF DEATH<br><b>Montgomery Co</b>                                          |                                                                                                           |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  | 10b. COUNTY<br><b>Montgomery Co</b>                                                                                                                                                      |  | 10c. CITY, TOWN OR LOCATION<br><b>Silver Spring</b>                                  |                                                                                                           |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                          |  |                                                                                      |                                                                                                           |
| 10e. STREET AND NUMBER<br><b>2601 Bel Pre Road</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  | 10f. ZIP CODE<br><b>20906</b>                                                                                                                                                            |  | 10g. CITIZEN OF WHAT COUNTRY?                                                        |                                                                                                           |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                      |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>              |                                                                                                           |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)                                                                                                                                                                                                 |  | 16b. KIND OF BUSINESS/INDUSTRY                                                                                                                                                           |  |                                                                                      |                                                                                                           |
| 17. FATHER'S NAME (First, Middle, Last)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)                                                                                                                                        |  |                                                                                      |                                                                                                           |
| 19a. INFORMANT'S NAME (Type/Print)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)                                                                                            |  |                                                                                      |                                                                                                           |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                       |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)                                                                                                                                                                                                                            |  | DATE                                                                                                                                                                                     |  | 20c. LOCATION — City or Town, State                                                  |                                                                                                           |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Ronald Wade, Dir</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 22. NAME AND ADDRESS OF FACILITY<br><b>State Anatomy Board<br/>655 W. Baltimore St, Balto, MD 21201</b>                                                                                                                                                                                                    |  |                                                                                                                                                                                          |  |                                                                                      |                                                                                                           |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failures. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sepsis</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>UTI</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>NIDDM ; ASCVD ; HTN ; w/o CVA</b> |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                          |  |                                                                                      | Approximate interval Between Onset and Death                                                              |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>NIDDM ; ASCVD ; HTN ; w/o CVA</b>                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                          |  |                                                                                      | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                          |  |                                                                                      |                                                                                                           |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                          |  |                                                                                      |                                                                                                           |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                          |  |                                                                                      |                                                                                                           |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                  |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                     |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                          |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |                                                                                                           |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                   |  |                                                                                      |                                                                                                           |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                          |  |                                                                                      |                                                                                                           |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                          |  |                                                                                      |                                                                                                           |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>C. Ozanne-Blankford</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  | 29c. LICENSE NUMBER<br><b>D43202</b>                                                                                                                                                     |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11-12-94</b>                               |                                                                                                           |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>C. Ozanne-Blankford 3305 N. Leisure World Blvd Silver Spring MD 20906</b>                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                          |  |                                                                                      |                                                                                                           |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |  | 32. REGISTRAR'S SIGNATURE<br><i>John Andrew Radtke</i>                                                                                                                                   |  |                                                                                      |                                                                                                           |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





94 33886

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                     |                                |                                                                                          |                                                                                                           |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Helen L. Cress                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |                                           | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>Nov. 16, 1994                                                                                                                                                 |                                | 3. TIME OF DEATH<br>7:30 P M                                                             |                                                                                                           |
| 4. SOCIAL SECURITY NUMBER<br>214-03-2578                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                             | 6. AGE (In yrs. last birthday)<br>92 YRS. | IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                                                                                                      | IF UNDER 24 HRS.<br>HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year)<br>Sept 19, 1902                                     |                                                                                                           |
| 8. FACILITY NAME (If not institution, give street and number)<br>Roland Park Place Care Center                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |                                           | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore                                                                                                                                                    |                                | 9c. COUNTY OF DEATH<br>Md                                                                |                                                                                                           |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                     |                                |                                                                                          |                                                                                                           |
| 10a. STATE<br>Md                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 10b. COUNTY                                                                                                                                                                                                                                                                                                |                                           | 10c. CITY, TOWN OR LOCATION<br>Baltimore                                                                                                                                                            |                                | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |                                                                                                           |
| 10e. STREET AND NUMBER<br>830 W. 40th Street                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |                                           | 10f. ZIP CODE<br>21211                                                                                                                                                                              |                                | 10g. CITIZEN OF WHAT COUNTRY?<br>USA                                                     |                                                                                                           |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                           |                                           | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |                                | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>white                      |                                                                                                           |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5 +)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Private Secretary                                                                                                                                                                         |                                           | 16b. KIND OF BUSINESS/INDUSTRY<br>Continental Can Co.                                                                                                                                               |                                |                                                                                          |                                                                                                           |
| 17. FATHER'S NAME (First, Middle, Last)<br>Henry Cress                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |                                           | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Agnes Millar                                                                                                                                   |                                |                                                                                          |                                                                                                           |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mildred Cress                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |                                           | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>213 Liberty Road, Federalsburg, Md. 21632                                                          |                                |                                                                                          |                                                                                                           |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                 |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Druid Ridge Cemetery 11/19                                                                                                                                                                                              |                                           | 20c. LOCATION — City or Town, State<br>Baltimore, Md.                                                                                                                                               |                                |                                                                                          |                                                                                                           |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Phillip A. Hays mo0550                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |                                           | 22. NAME AND ADDRESS OF FACILITY<br>Sterling Ashton Funeral Home<br>736 Edmondson Avenue, Balto, Md. 21228                                                                                          |                                |                                                                                          |                                                                                                           |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Septic Shock<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Decubitus Ulcer - Foot<br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF): |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                     |                                |                                                                                          | Approximate Interval Between Onset and Death                                                              |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Dementia Hypertension<br>Hypertension                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                     |                                |                                                                                          | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                     |                                |                                                                                          |                                                                                                           |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                     |                                |                                                                                          |                                                                                                           |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                           |                                                                                                                                                                                                     |                                |                                                                                          |                                                                                                           |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                       |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                     |                                           | 28b. TIME OF INJURY<br>M                                                                                                                                                                            |                                | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO     |                                                                                                           |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |                                           | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                        |                                |                                                                                          |                                                                                                           |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                     |                                |                                                                                          |                                                                                                           |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Dr. J. J. [Signature]                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |                                           | 29c. LICENSE NUMBER<br>D37133                                                                                                                                                                       |                                | 29d. DATE SIGNED (Month, Day, Year)<br>11/18/94                                          |                                                                                                           |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>830 W. 40th St. Baltimore MD 21211                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                     |                                |                                                                                          |                                                                                                           |
| 31. DATE FILED (Month, Day, Year)<br>NOV 18 1994                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |                                           |                                                                                                                                                                                                     |                                |                                                                                          |                                                                                                           |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94-6587-510  
B.K.S

94 33887

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |                                              |                                                                                                       |                                                                                                 |                                                                                                                                         |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|-------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>ROBERT COMMODORE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>NOV. 14 94                                                                                                                                                                  |                                              | 3. TIME OF DEATH<br>10:29 A.M.                                                                        |                                                                                                 |                                                                                                                                         |  |
| 4. SOCIAL SECURITY NUMBER<br>216-24-8232                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br>64 YRS.                                                                                                                                                       |                                              | 7. DATE OF BIRTH (Month, Day, Year)<br>June 18 30                                                     |                                                                                                 | 8. BIRTHPLACE (State or Foreign Country)<br>MD                                                                                          |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>720 EAST 20TH STREET                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE CITY                                                                                                                                           |                                              |                                                                                                       | 9c. COUNTY OF DEATH<br>-----                                                                    |                                                                                                                                         |  |
| 10a. STATE<br>MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 10b. COUNTY<br>-----                                                                                                                                                                                                                                                                           |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore City                                                                                                                                                   |                                              |                                                                                                       | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |                                                                                                                                         |  |
| 10e. STREET AND NUMBER<br>720 E. 20th Street                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  | 10f. ZIP CODE<br>21218                                                                                                                                                                          |                                              | 10g. CITIZEN OF WHAT COUNTRY?<br>USA                                                                  |                                                                                                 |                                                                                                                                         |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |                                              |                                                                                                       | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>Black                             |                                                                                                                                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 10 College (1-4 or 5+) -----                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Self Employed                                                                                                                                                                 |  |                                                                                                                                                                                                 | 16b. KIND OF BUSINESS/INDUSTRY<br>Contractor |                                                                                                       |                                                                                                 |                                                                                                                                         |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>George Moultray                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Mary Elizabeth (Unknown)                                                                                                                   |                                              |                                                                                                       |                                                                                                 |                                                                                                                                         |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Kevin Commodore<br>Christina Commodore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>403 E. North Av. 2nd Fl. Balto., MD 21202                                                      |                                              |                                                                                                       |                                                                                                 |                                                                                                                                         |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                 |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Mt. Zion Cemetery 11/17/94                                                                                                                                                                                  |  | 20c. LOCATION — City or Town, State<br>Lansdown, MD                                                                                                                                             |                                              |                                                                                                       |                                                                                                 |                                                                                                                                         |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Joseph R. Walters, Jr.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br>Unity Funeral Home<br>108 W. North Av. Balto., MD 21201                                                                                                     |                                              |                                                                                                       |                                                                                                 |                                                                                                                                         |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Atherosclerotic cardiovascular disease</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |                                              |                                                                                                       |                                                                                                 | Approximate Interval Between Onset and Death                                                                                            |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |                                              | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |                                                                                                 | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |                                              |                                                                                                       |                                                                                                 |                                                                                                                                         |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |                                              |                                                                                                       |                                                                                                 |                                                                                                                                         |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Nomicide                                                                                                                                                                                                                                                                                                                             |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                        |                                              | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO           |                                                                                                 | 28d. DESCRIBE NOW INJURY OCCURRED                                                                                                       |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                    |                                              |                                                                                                       |                                                                                                 |                                                                                                                                         |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |                                              |                                                                                                       |                                                                                                 |                                                                                                                                         |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br>O.C.M.E                                                                                                                                                                  |                                              | 29d. DATE SIGNED (Month, Day, Year)<br>NOV. 15, 1994                                                  |                                                                                                 |                                                                                                                                         |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>David R Fowler</i> 111 Penn Street, Baltimore, Maryland 21201                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |                                              |                                                                                                       |                                                                                                 |                                                                                                                                         |  |
| 31. DATE FILED (Month, Day, Year)<br>NOV 18 1994                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |                                              |                                                                                                       |                                                                                                 |                                                                                                                                         |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

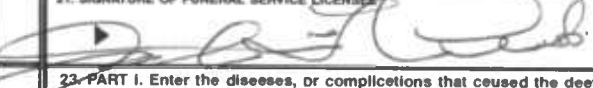

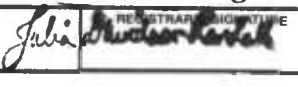
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33888

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                                                                      |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>SANDRA L. CONLON</b>                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  | 2. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>16</b> YEAR <b>94</b>                                                                                                                                    |  | 3. TIME OF DEATH<br><b>8:15P.</b> M                                                                                                                  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>215-58-3952</b>                                                                                                                                                                                                                                                                                                                                                                                  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                             |  | 6. AGE (In yrs. last birthday)<br><b>42</b> YRS.                                                                                                                                                    |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>06/15/52</b>                                                                                               |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>St. Agnes Hospital</b>                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>                                                                                                                                             |  | 9c. COUNTY OF DEATH                                                                                                                                  |  |
| 10a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |  | 10b. COUNTY<br><b>Baltimore</b>                                                                                                                                                                     |  | 10c. CITY, TOWN OR LOCATION<br><b>Arbutus</b>                                                                                                        |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                                                                      |  |
| 10e. STREET AND NUMBER<br><b>1212 Oakland Terrace Road</b>                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                            |  | 10f. ZIP CODE<br><b>21227</b>                                                                                                                                                                       |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                       |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                           |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                        |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>white</b>                                                                           |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)                                                                                                                                                                                                                                                                                                  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Customer Representative</b>                                                                                                                                                            |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Columbia Insurance</b>                                                                                                                                         |  |                                                                                                                                                      |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Raymond Baker</b>                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Margalee Ingram</b>                                                                                                                         |  |                                                                                                                                                      |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Patricia L. Bromwell</b>                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>405 Duncan Lane, Hampstead, MD 21074</b>                                                        |  |                                                                                                                                                      |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metro Crematory, Inc. 11/21</b>                                                                                                                                                                                      |  | 20c. LOCATION — City or Town, State<br><b>Catonsville, Maryland</b>                                                                                                                                 |  |                                                                                                                                                      |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Ambrose Funeral Home, Inc.<br/>1328 Sulphur Spring Road, Arbutus, MD 21227</b>                                                                               |  |                                                                                                                                                      |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                                                                      |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →                                                                                                                                                                                                                                                                                                                                                                |  | a. <b>ASPIRATION OF GASTRIC CONTENTS</b><br>DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                               |  |                                                                                                                                                                                                     |  | Approximate Interval Between Onset and Death<br><b>Minutes</b>                                                                                       |  |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                          |  | b. <b>UROSEPSIS</b><br>DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                     |  | <b>Days</b>                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | c. <b>HYDRONEPHROSIS</b><br>DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                     |  | <b>Years</b>                                                                                                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | d. <b>METASTATIC CARCINOID TUMOR</b>                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                     |  | <b>Years</b>                                                                                                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                                                                      |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                                                                      |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                           |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                                                                                      |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                        |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                     |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                            |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                          |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                        |  |                                                                                                                                                      |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                                                                                                                                                                               |  | 29c. LICENSE NUMBER<br><b>D30802</b>                                                                                                                                                                |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/17/94</b>                                                                                               |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. Jean M. Colandrea, St. Agnes Hospital, 900 Caton Ave., Baltimore, Md. 21229</b>                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                                                                      |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                                                                      |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33889

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Elvan Hilyard Clayton</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                            |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11/ 15/ 1994</b>                                                                                                                                                                                                                                                                                                                                                                    |  | 3. TIME OF DEATH<br>M<br><b>M</b>                                                                                                                                              |  |
| 4. SOCIAL SECURITY NUMBER<br><b>215-14-4961</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>93</b> YRS.                                                                                                                                                                                                                                                                                                                                                                             |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>10/20/01</b>                                                                                                                         |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                            |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>612 Gun Road</b>                                                                                                                                                                                                                                                                                                                                        |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Arbutus</b>                                                                                                                          |  |
| 9c. COUNTY OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                            |  | 10a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                      |  | 10b. COUNTY<br><b>Baltimore</b>                                                                                                                                                |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Arbutus</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                            |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                              |  | 10e. STREET AND NUMBER<br><b>612 Gun Road</b>                                                                                                                                  |  |
| 10f. ZIP CODE<br><b>21227</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                            |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                                                                                                                                               |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                            |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                              |  |                                                                                                                                                                                |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>white</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                            |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                |  |
| 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Construction</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                            |  | 17. FATHER'S NAME (First, Middle, Last)<br><b>William A. Clayton</b>                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                |  |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Amelia Moog</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                            |  | 19a. INFORMANT'S NAME (Type/Print)<br><b>Jean Clayton</b>                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                |  |
| 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>612 Gun Road, Arbutus, MD 21227</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                            |  | 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |  |                                                                                                                                                                                |  |
| 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Lakeview Cemetery</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                            |  | 20c. LOCATION — City or Town, State<br><b>11/18 Sykesville, Maryland</b>                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Joseph J. Ambrose, Jr.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Ambrose Funeral Home, Inc.<br/>1328 Sulphur Spring Rd., Arbutus, MD 21227</b>                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pneumonia</b><br>Approximate Interval Between Onset and Death <b>24 hrs</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. <b>Severely</b><br>c. <b>arteriosclerotic heart disease</b><br>d. <b>9 yrs</b> |  |                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                               |  |                                                                                                                                                                                |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                    |  |                                                                            |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>11/15/94</b>                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                |  |
| 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                            |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                            |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                            |  | 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Bradley D. Hughes</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                            |  | 29c. LICENSE NUMBER<br><b>DO 2099</b>                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>11-16-94</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                            |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                            |  | 32. REGISTRAR'S SIGNATURE<br><b>John Andrew Ruffell</b>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





94 33890

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                         |                                           |                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                     |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>WILLIAM N. CARROLL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                         |                                           | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>10/ 29/ 94                                                                                                                                       |  | 3. TIME OF DEATH<br>9:05 a m                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                     |
| 4. SOCIAL SECURITY NUMBER<br>218-48-3450                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                              | 6. AGE (In yrs. last birthday)<br>47 YRS. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>4/ 21 / 1947                                                                                                                                 |  | 8. BIRTHPLACE (State or Foreign Country)<br>MD                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                     |
| 9a. FACILITY NAME (If not institution, give street and number)<br>BON SECOUR HOSPITAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                         |                                           | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE                                                                                                                                       |  | 9c. COUNTY OF DEATH<br>MD                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                     |
| 10a. STATE<br>MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                         |                                           | 10b. COUNTY<br>BALTO.                                                                                                                                                                  |  | 10c. CITY, TOWN OR LOCATION<br>BALTO.                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                     |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                         |                                           | 10e. STREET AND NUMBER<br>222 WOODYEAR STREET                                                                                                                                          |  | 10f. ZIP CODE<br>21223                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                     |
| 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                         |                                           | 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                                 |                                                                                                                                                     |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                         |                                           | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>AFR. AMERICAN                                                                                                            |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) BALTO. SCHOOL SYSTEM                                                                                                                                                                                                                                                                                    |                                                                                                                                                     |
| 16. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>BALTO. SCHOOL SYSTEM                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                         |                                           | 17. FATHER'S NAME (First, Middle, Last)<br>WILLIAM N. CARROLL SR.                                                                                                                      |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>ALETHIA CARROLL                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                     |
| 19. INFORMANT'S NAME (Type/Print)<br>ALETHIA CARROLL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                         |                                           | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2418 W. FRANKLIN ST. BALTO. MD 21223                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                     |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                         |                                           | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place)<br>MT. CALVARY CEM. 11/3/94                                                                           |  | 20c. LOCATION — City or Town, State<br>GLEN BURNIE, MD                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                     |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                         |                                           | 22. NAME AND ADDRESS OF FACILITY<br>ESTEP BROTHERS FUNERAL HOME P.A.<br>1300 EUTAW PLACE BALTO. MD 21217                                                                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                     |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. malignant lymphoma of lung & liver metastases 6 months<br>b. Acquired immunodeficiency syndrome 10 yrs<br>c. Hypokalemia / cachexia 2 yrs<br>d. Renal failure 2 yrs<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                                         |                                           |                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  | Approximate interval Between Onset and Death                                                                                                        |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>pneumonia<br>liver metastases                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                         |                                           |                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                           |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                         |                                           |                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                           |                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                     |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                           |  | 28a. DATE OF INJURY (Month, Day, Year)<br>4                                                                                                                                                                                                                                                             |                                           | 28b. TIME OF INJURY<br>4 M                                                                                                                                                             |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                     |
| 28d. DESCRIBE HOW INJURY OCCURRED<br>4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>4                                                                                                                                                                                                             |                                           | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br>4                                                                                                      |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                                                                                                                     |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                         |                                           | 29c. LICENSE NUMBER<br>D31865                                                                                                                                                          |  | 29d. DATE SIGNED (Month, Day, Year)<br>11/18/94                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                     |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Mien-D. Kidung Rm 206 824 N Eutaw street Balt md 21201                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                         |                                           |                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                     |
| 31. DATE FILED (Month, Day, Year)<br>NOV 18 1994                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                         |                                           | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                     |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for filing, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                         |                                                                                                 |                                                                                                       |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>BRUCE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                                              |  | 2. DATE OF DEATH<br>MONTH <b>NOV</b> DAY <b>08</b> YEAR <b>1994</b>                                                                                                                             |  |                                                                                             |                                                                         | 3. TIME OF DEATH<br><b>7:15 A M</b>                                                             |                                                                                                       |
| 4. SOCIAL SECURITY NUMBER<br><b>216-86-2765</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                                                   |  | 6. AGE (In yrs. last birthday)<br><b>27</b> YRS.                                                                                                                                                |  | IF UNDER 1 YEAR<br>MONTHS <b>05</b> DAYS <b>26</b>                                          |                                                                         | 7. DATE OF BIRTH (Month, Day, Year)<br><b>05-26-67</b>                                          |                                                                                                       |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                                              |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>I-95, SOUTHBOUND MILEPOST 73.8</b>                                                                                         |  |                                                                                             |                                                                         | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>HARFORD</b>                                           |                                                                                                       |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                         |                                                                                                 |                                                                                                       |
| 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 10b. COUNTY<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                              |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>                                                                                                                                                 |  |                                                                                             |                                                                         | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |                                                                                                       |
| 10e. STREET AND NUMBER<br><b>2309 DIVISION STREET</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                              |  | 10f. ZIP CODE<br><b>21217</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                 |                                                                         |                                                                                                 |                                                                                                       |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                 |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |                                                                                             | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>BLACK</b> |                                                                                                 |                                                                                                       |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>ROAD WORKER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                              |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)                                                                                      |  |                                                                                             | 16b. KIND OF BUSINESS/INDUSTRY                                          |                                                                                                 |                                                                                                       |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>ERNEST L. COOLEY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                              |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>SHIRLEY D. PERKINS</b>                                                                                                                  |  |                                                                                             |                                                                         |                                                                                                 |                                                                                                       |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>ERNEST L. COOLEY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                              |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2309 DIVISION ST. BALTIMORE MD. 21217</b>                                                   |  |                                                                                             |                                                                         |                                                                                                 |                                                                                                       |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                              |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>MT. ZION</b>                                                                                              |  |                                                                                             | 20c. LOCATION — City or Town, State<br><b>11-19-1994 LANSDOWNE MD.</b>  |                                                                                                 |                                                                                                       |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                              |  | 22. NAME AND ADDRESS OF FACILITY<br><b>ALBERT P. WYLIE F/H PA</b><br><b>638 N. GILMOR STREET 21217</b>                                                                                          |  |                                                                                             |                                                                         |                                                                                                 |                                                                                                       |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Multiple injuries</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                         |                                                                                                 | Approximate Interval Between Onset and Death                                                          |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                         |                                                                                                 | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                         |                                                                                                 |                                                                                                       |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                         |                                                                                                 |                                                                                                       |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>ACCIDENT SCENE</b> |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                         |                                                                                                 |                                                                                                       |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input checked="" type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                        |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>11/08/94</b>                                                                                                                                                                                                                                                                    |  | 28b. TIME OF INJURY<br><b>0556 M</b>                                                                                                                                                            |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |                                                                         | 28d. DESCRIBE HOW INJURY OCCURRED<br><b>STRUCK BY PICKUP TRUCK</b>                              |                                                                                                       |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>INTERSTATE ROADWAY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>I-95, SOUTHBOUND, MILEPOST 73.8</b>                                                                                                                                                                                                       |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                         |                                                                                                 |                                                                                                       |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                         |                                                                                                 |                                                                                                       |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Donald G. Wright MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                              |  | 29c. LICENSE NUMBER<br><b>O.C.M.E.</b>                                                                                                                                                          |  |                                                                                             | 29d. DATE SIGNED (Month, Day, Year)<br><b>NOV. 08, 1994</b>             |                                                                                                 |                                                                                                       |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DONALD G. WRIGHT MD 111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                         |                                                                                                 |                                                                                                       |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                              |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                   |  |                                                                                             |                                                                         |                                                                                                 |                                                                                                       |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                                 |  |                                                                                                           |  |                                                                                                                                             |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ALEXANDER CROCKER JR.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                         |  | 2. DATE OF DEATH<br>MONTH <b>NOV.</b> DAY <b>13</b> YEAR <b>94</b>                                                                                                                                  |  | 3. TIME OF DEATH<br><b>3:55P</b> M                                                              |  |                                                                                                           |  |                                                                                                                                             |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-72-1786</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                                                                                                                                                          |  | 6. AGE (In yrs. last birthday)<br><b>36</b> YRS.                                                                                                                                                    |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>August 3, 1958</b>                                    |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                                               |  |                                                                                                                                             |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>3516 FAIRVIEW AVENUE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                         |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>                                                                                                                                        |  |                                                                                                 |  | 9c. COUNTY OF DEATH                                                                                       |  |                                                                                                                                             |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                         |  | 10b. COUNTY                                                                                                                                                                                         |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                                                 |  | 10d. INSIDE CITY LIMITS<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                   |  |                                                                                                                                             |  |
| 10e. STREET AND NUMBER<br><b>3516 Fairview Avenue</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                         |  | 10f. ZIP CODE<br><b>21216</b>                                                                                                                                                                       |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                  |  |                                                                                                           |  |                                                                                                                                             |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                        |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                         |  |                                                                                                           |  |                                                                                                                                             |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>Lanette Middle</b> College (1-4 or 5+) <b>Home Improver</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                         |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Home Improver</b>                                                                  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Laborer</b>                                                |  |                                                                                                           |  |                                                                                                                                             |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Alexander Crocker SR.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                         |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Shirley C. Mongle</b>                                                                                                                       |  |                                                                                                 |  |                                                                                                           |  |                                                                                                                                             |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Alexander Crocker Sr</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                         |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3516 Fairview Ave. Baltimore, Maryland 21216</b>                                                |  |                                                                                                 |  |                                                                                                           |  |                                                                                                                                             |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                             |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Mount Zion Cem.</b>                                                                                                                                                                                               |  | DATE                                                                                                                                                                                                |  | 20c. LOCATION — City or Town, State<br><b>LANSDOWNE Maryland</b>                                |  |                                                                                                           |  |                                                                                                                                             |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Nancy M. Wallace</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                         |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Nancy M. Wallace Funeral Home<br/>3405 W. Franklin St. 21229 Service</b>                                                                                     |  |                                                                                                 |  |                                                                                                           |  |                                                                                                                                             |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. <b>NARCOTIC AND ALCOHOL INTOXICATION</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br><br>d. |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                                 |  | Approximate Interval Between Onset and Death                                                              |  |                                                                                                                                             |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                                 |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                                 |  |                                                                                                           |  |                                                                                                                                             |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Suicide 7 <input checked="" type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Undetermined                                                                                                                                                                                                                                                                                                |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>11-13-94 FOUND</b>                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>3:55 P M</b>                                                                                                                                                              |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED<br><b>UNKNOWN</b>                                                       |  |                                                                                                                                             |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>HOME</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                         |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>3516 FAIRVIEW AVE. BALTIMORE, MD.</b>                                                                            |  |                                                                                                 |  |                                                                                                           |  |                                                                                                                                             |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                                 |  |                                                                                                           |  |                                                                                                                                             |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>[Signature]</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                         |  | 29c. LICENSE NUMBER<br><b>O.C.M.E.</b>                                                                                                                                                              |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>NOV. 14/94</b>                                        |  |                                                                                                           |  |                                                                                                                                             |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MARIO F. GOLIE JR MD 111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                                 |  |                                                                                                           |  |                                                                                                                                             |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                         |  | 32. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                                                                                                                                     |  |                                                                                                 |  |                                                                                                           |  |                                                                                                                                             |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33893

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Kathleen Dollahite</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                            |  | 2. DATE OF DEATH<br>MONTH <b>Nov.</b> DAY <b>16</b> YEAR <b>1994</b>                                                                                                                                                                                                                           |  | 3. TIME OF DEATH<br><b>4:05 P.M.</b>                                                                                                                                           |  |
| 4. SOCIAL SECURITY NUMBER<br><b>219-05-4232</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>73</b> YRS.                                                                                                                                                                                                                                               |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Nov. 21, 1920</b>                                                                                                                 |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                            |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Meridian-Franklin Woods</b>                                                                                                                                                                                               |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>                                                                                                                        |  |
| 9c. COUNTY OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                            |  | 10a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                       |  | 10b. COUNTY<br><b>Baltimore</b>                                                                                                                                                |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Essex</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                            |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                |  | 10e. STREET AND NUMBER<br><b>1000 Franklin Ave.</b>                                                                                                                            |  |
| 10f. ZIP CODE<br><b>21221</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                            |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                                                                                                                    |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                            |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                                |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                                                                                                     |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>8th</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                            |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Howard Uniform Co.</b>                                                                                                                                                     |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Clothing</b>                                                                                                                              |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Charles Williams</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Lottie Brosh</b>                                                                                                                                                                                                                       |  |                                                                                                                                                                                |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Charlotte Dvorak</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>574A Renee Drive Joppa Md. 21085</b>                                                                                                                                                       |  |                                                                                                                                                                                |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                            |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Holy Redeemer 11/19/94</b>                                                                                                                                                                               |  | 20c. LOCATION — City or Town, State<br><b>Baltimore Md.</b>                                                                                                                    |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>R. Terry Connolly</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Connolly Funeral Home of Essex<br/>300 Mace Ave. Baltimore Md. 21221</b>                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic ovarian carcinoma</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                            |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                             |  |                                                                                                                                                                                |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                             |  |                                                                            |  | 28a. DATE OF INJURY<br>(Month, Day, Year)                                                                                                                                                                                                                                                      |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                            |  | 28d. DESCRIBE NOW INJURY OCCURRED                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                            |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                   |  |                                                                                                                                                                                |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                              |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>L. P. Heflinger</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                            |  | 29c. LICENSE NUMBER<br><b>D35410</b>                                                                                                                                                                                                                                                           |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/17/94</b>                                                                                                                         |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>L. P. Heflinger</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                            |  | 32. REGISTRAR'S SIGNATURE<br><i>J. B. Davidson</i>                                                                                                                                                                                                                                             |  |                                                                                                                                                                                |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





94 33894

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                     |  |                                                                                      |                                                                                                                                             |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Margaret M. Deinlein                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                 |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>Nov. 13, 1994                                                                                                                                                 |  | 3. TIME OF DEATH<br>2:00 <sup>a</sup> M                                              |                                                                                                                                             |
| 4. SOCIAL SECURITY NUMBER<br>215-97-8345                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                  |  | 6. AGE (In yrs. last birthday)<br>89 YRS.                                                                                                                                                           |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Jan. 19, 1905                                 |                                                                                                                                             |
| 8. BIRTHPLACE (State or Foreign Country)<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 9a. FACILITY NAME (If not institution, give street and number)<br>STELLA MARIS Hospice                                                                                                                                                                                                          |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Towson                                                                                                                                                       |  | 9c. COUNTY OF DEATH<br>BALTIMORE                                                     |                                                                                                                                             |
| 10a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                 |  | 10b. COUNTY<br>BALTIMORE                                                                                                                                                                            |  | 10c. CITY, TOWN OR LOCATION<br>Towson                                                |                                                                                                                                             |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                     |  |                                                                                      |                                                                                                                                             |
| 10e. STREET AND NUMBER<br>2300 Dulaney Valley Road                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                 |  | 10f. ZIP CODE<br>21204                                                                                                                                                                              |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                              |                                                                                                                                             |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>WHITE                  |                                                                                                                                             |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>10 YRS.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>TYPIST                                                                                                                                                                         |  | 16b. KIND OF BUSINESS/INDUSTRY<br>U.S.F. + G.                                                                                                                                                       |  |                                                                                      |                                                                                                                                             |
| 17. FATHER'S NAME (First, Middle, Last)<br>GEORGE Deinlein                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                 |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>ELIZABETH M. STABB                                                                                                                             |  |                                                                                      |                                                                                                                                             |
| 19a. INFORMANT'S NAME (Type/Print)<br>GERTRUDE LOWIE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                 |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>726 STEVENSON LANE Towson, MD. 21286                                                               |  |                                                                                      |                                                                                                                                             |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                 |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place)<br>Holy Redeemer Cem 11-16                                                                                                                                                                                    |  | 20c. LOCATION — City or Town, State<br>BALTO. MD.                                                                                                                                                   |  |                                                                                      |                                                                                                                                             |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>[Signature]                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                 |  | 22. NAME AND ADDRESS OF FACILITY<br>EVANS CHAPEL OF CHIMES<br>2325 YORK ROAD - Timonium                                                                                                             |  |                                                                                      |                                                                                                                                             |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Cerebral Vascular Disease<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                     |  |                                                                                      | Approximate Interval Between Onset and Death                                                                                                |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                     |  |                                                                                      | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                     |  |                                                                                      | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                      |                                                                                                                                             |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                 |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                          |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                            |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 28d. DESCRIBE NOW INJURY OCCURRED                                                                                                                                                                                                                                                               |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                              |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)         |                                                                                                                                             |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                     |  |                                                                                      |                                                                                                                                             |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Kendall Faulkner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                 |  | 29c. LICENSE NUMBER<br>D00643                                                                                                                                                                       |  | 29d. DATE SIGNED (Month, Day, Year)<br>11/14/94                                      |                                                                                                                                             |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Dr. Kendall Faulkner 2300 Dulaney Valley Road                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                     |  |                                                                                      |                                                                                                                                             |
| 31. DATE FILED (Month, Day, Year)<br>NOV 18 1994                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                 |  | 32. REGISTRAR'S SIGNATURE<br>[Signature]                                                                                                                                                            |  |                                                                                      |                                                                                                                                             |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the paper discusses the importance of maintaining accurate records of all transactions. It emphasizes that this is essential for the proper management of the company's finances and for ensuring that all stakeholders are kept informed of the company's financial health.

2. The second part of the paper discusses the importance of maintaining accurate records of all transactions. It emphasizes that this is essential for the proper management of the company's finances and for ensuring that all stakeholders are kept informed of the company's financial health.

3. The third part of the paper discusses the importance of maintaining accurate records of all transactions. It emphasizes that this is essential for the proper management of the company's finances and for ensuring that all stakeholders are kept informed of the company's financial health.

4. The fourth part of the paper discusses the importance of maintaining accurate records of all transactions. It emphasizes that this is essential for the proper management of the company's finances and for ensuring that all stakeholders are kept informed of the company's financial health.

5. The fifth part of the paper discusses the importance of maintaining accurate records of all transactions. It emphasizes that this is essential for the proper management of the company's finances and for ensuring that all stakeholders are kept informed of the company's financial health.

6. The sixth part of the paper discusses the importance of maintaining accurate records of all transactions. It emphasizes that this is essential for the proper management of the company's finances and for ensuring that all stakeholders are kept informed of the company's financial health.

7. The seventh part of the paper discusses the importance of maintaining accurate records of all transactions. It emphasizes that this is essential for the proper management of the company's finances and for ensuring that all stakeholders are kept informed of the company's financial health.

8. The eighth part of the paper discusses the importance of maintaining accurate records of all transactions. It emphasizes that this is essential for the proper management of the company's finances and for ensuring that all stakeholders are kept informed of the company's financial health.

9. The ninth part of the paper discusses the importance of maintaining accurate records of all transactions. It emphasizes that this is essential for the proper management of the company's finances and for ensuring that all stakeholders are kept informed of the company's financial health.

10. The tenth part of the paper discusses the importance of maintaining accurate records of all transactions. It emphasizes that this is essential for the proper management of the company's finances and for ensuring that all stakeholders are kept informed of the company's financial health.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

10f, 10d, 10g,  
Item#1, 8, 10b, 10e, 11, 12, 13, 15, 16a, 16b, 17, 19a, 19b, 18, 20a, 20b, 20c, 20d, 20e, 20f, 20g, 20h, 20i, 20j, 20k, 20l, 20m, 20n, 20o, 20p, 20q, 20r, 20s, 20t, 20u, 20v, 20w, 20x, 20y, 20z, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

1. DECEDENT'S NAME (First, Middle, Last) LEE L. DRUMMER  
2. DATE OF DEATH 11-8-94 3. TIME OF DEATH 6:00 AM  
4. SOCIAL SECURITY NUMBER 218 74 3004 5. SEX 1 ☒ M ☐ F 6. AGE (In yrs. last birthday) 35 YRS. 7. DATE OF BIRTH (Month, Day, Year) 6-16-59 8. BIRTHPLACE (State or Foreign Country) MARYLAND  
9a. FACILITY NAME (If not institution, give street and number) University Hospital 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore 9c. COUNTY OF DEATH na  
10a. STATE Maryland 10b. COUNTY BALTIMORE CITY 10c. CITY, TOWN OR LOCATION Baltimore 10d. INSIDE CITY LIMITS? ☒ YES ☐ NO  
10e. STREET AND NUMBER 920 N. MONROE STREET 10f. ZIP CODE 21223 21217 10g. CITIZEN OF WHAT COUNTRY? USA  
11. MARITAL STATUS ☒ Never Married ☐ Married ☐ Widowed ☐ Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? ☐ YES ☒ NO IF YES, GIVE WAR OR DATES 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ YES ☒ NO Specify: 14. RACE — American Indian, Black, White, etc. Specify: Black  
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) PRODUCTION WORKER 16b. KIND OF BUSINESS/INDUSTRY GRAPHICS  
17. FATHER'S NAME (First, Middle, Last) LEE ELISE DRUMMER, SR. 18. MOTHER'S NAME (First, Middle, Maiden Surname) EVA JOHNSON  
19a. INFORMANT'S NAME (Type/Print) LORYANNE EVITT TAYLOR 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 906 HONEYWOOD PLACE BALTIMORE, MD 21221  
20a. METHOD OF DISPOSITION ☐ Burial ☒ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) in state removal 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) METRO CREMATORY, INC. 11/17/94 20c. LOCATION — City or Town, State BALTIMORE, MD  
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, Dir 22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655W. Baltimore St, Balto, MD 21201  
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death  
IMMEDIATE CAUSE (Final disease or condition resulting in death) Sepsis  
DUE TO (OR AS A CONSEQUENCE OF):  
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST AIDS  
DUE TO (OR AS A CONSEQUENCE OF):  
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. End Stage Renal Disease  
24a. WAS AN AUTOPSY PERFORMED? ☐ YES ☒ NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? ☐ YES ☒ NO  
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐  
25. WAS CASE REFERRED TO MEDICAL EXAMINER? ☐ YES ☒ NO 26. PLACE OF DEATH (Check only one) ☒ HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ DOA ☐ OTHER: ☐ Nursing Home ☐ Residence ☐ Other (Specify)  
27. MANNER OF DEATH ☒ Natural ☐ Pending Investigation ☐ Accident ☐ Suicide ☐ Homicide ☐ Could not be determined 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 28c. INJURY AT WORK? ☐ YES ☒ NO 28d. DESCRIBE HOW INJURY OCCURRED  
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28b. LOCATION (Street and Number or Rural Route Number, City or Town, State)  
29a. CERTIFIER (Check only one) ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
29b. SIGNATURE AND TITLE OF CERTIFIER Gregory KumKumaw, M.D. 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 11/8/94  
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Gregory KumKumaw, Univ. of MD Hospital, Baltimore, MD  
31. DATE FILED (Month, Day, Year) 11/8/94 32. REGISTRAR'S SIGNATURE NOV 18 1994 Johanna Anderson-Rodell



94 33896

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |                                                                                                |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>CAROLINE F. DELANEY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>NOV 10 1994                                                                                                                                                                                                                                                                                                                                                                                |  | 3. TIME OF DEATH<br>9:15 P M                                                                                                                                                           |                                                                                                |
| 4. SOCIAL SECURITY NUMBER<br>067-26-5251                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>93 YRS.                                                                                                                                                                                                                                                                                                                                                                                        |  | 7. DATE OF BIRTH (Month, Day, Year)<br>JUNE 17 1901                                                                                                                                    |                                                                                                |
| 8. BIRTHPLACE (State or Foreign Country)<br>N.Y.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                |  | 9a. FACILITY NAME (If not institution, give street and number)<br>LORIE NURSING HOME                                                                                                                                                                                                                                                                                                                                             |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>COLUMBIA                                                                                                                                        |                                                                                                |
| 9c. COUNTY OF DEATH<br>HOWARD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                |  | 10a. STATE<br>MD                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 10b. COUNTY<br>HOWARD                                                                                                                                                                  |                                                                                                |
| 10c. CITY, TOWN OR LOCATION<br>COLUMBIA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                              |  | 10e. STREET AND NUMBER<br>6277 COBBLER COURT                                                                                                                                           |                                                                                                |
| 10f. ZIP CODE<br>21045                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                                                                                                                                                                                                                                                                                                             |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |                                                                                                |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                              |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>WHITE                                                                                                                    |                                                                                                |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (9-12) 8 College (1-4 or 5+) NONE                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>TELEPHONE OPERATOR                                                                                                                                                                                                                                                                                                 |  | 16b. KIND OF BUSINESS/INDUSTRY<br>NEW YORK STOCK EXCHANGE                                                                                                                              |                                                                                                |
| 17. FATHER'S NAME (First, Middle, Last)<br>JOHN WILLIAM WICHERT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>LILLIAN LORETTA ROTHMEAL                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                        |                                                                                                |
| 19a. INFORMANT'S NAME (Type/Print)<br>DAPHNE T. JACKSON (GRANDDAUGHTER)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6277 COBBLER COURT, COLUMBIA, MD 21045                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                        |                                                                                                |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                          |  |                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>CYPRESS HILLS CEMETERY NOV 16, 1994                                                                                                                                                                                                                                                                                                           |  | 20c. LOCATION — City or Town, State<br>BROOKLYN, N.Y.                                                                                                                                  |                                                                                                |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Leroy M. Witzke</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br>LEROY M & RUSSELL C WITZKE FUNERAL HOME<br>5555 TWIN KNOLLS RD, COLUMBIA, MD 21045                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                        |                                                                                                |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Pneumonia</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        | Approximate Interval Between Onset and Death                                                   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>HTN, Dementia</i>                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |                                                                                                |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                                                                                                                       |  |                                                                                                                                                                                        |                                                                                                |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                           |  |                                                                                |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                           |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                  |                                                                                                |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                 |                                                                                                |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                        |                                                                                                |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Marshall Freeman D</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                |  | 29c. LICENSE NUMBER<br>H37211                                                                                                                                                                                                                                                                                                                                                                                                    |  | 29d. DATE SIGNED (Month, Day, Year)<br>11/18/94                                                                                                                                        |                                                                                                |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>MARSHALL FREEMAN D 2 KUAL N., COLUMBIA MD 21045                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |                                                                                                |
| 31. DATE FILED (Month, Day, Year)<br>NOV 18 1994                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Rodriguez</i>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                        |                                                                                                |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33897

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>CLARENCE ALLISON DUTTINGER</b>                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov. 14 1994</b>                                                                                                                                       |  | 3. TIME OF DEATH<br><b>3:36 P. M.</b>                                                       |  |
| 4. SOCIAL SECURITY NUMBER<br><b>202 09 5987</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>81 YRS.</b>                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>6-23-1913</b>                                     |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Penna</b>                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  | 9. FACILITY NAME (If not institution, give street and number)<br><b>COFFMAN NURSING HOME</b>                                                                                                    |  |                                                                                             |  |
| 10. CITY, TOWN OR LOCATION OF DEATH<br><b>HAGERSTOWN</b>                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  | 11. COUNTY OF DEATH<br><b>Wash.</b>                                                                                                                                                             |  |                                                                                             |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                |  | 10b. COUNTY<br><b>Washington Co</b>                                                                                                                                                                                                                                                            |  | 10c. CITY, TOWN OR LOCATION<br><b>Hagerstown</b>                                                                                                                                                |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO        |  |
| 10e. STREET AND NUMBER<br><b>1304 Pennsylvania Avenue</b>                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  | 10f. ZIP CODE<br><b>21740</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                 |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                               |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>No</b>                                                                                                                                   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>12</b>                                                                                                                                                                                                                                                                                                        |  | 16. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Carpenter</b>                                                                                                                                                               |  | 16b. KIND OF BUSINESS/INDUSTRY                                                                                                                                                                  |  |                                                                                             |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Edward Duttinger</b>                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Iva Ellen Auker</b>                                                                                                                     |  |                                                                                             |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs Virginia Duttinger</b>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1083 Marshall St, Hagerstown, MD 21740</b>                                                  |  |                                                                                             |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)                                                                                                                                                                                                                |  | DATE                                                                                                                                                                                            |  | 20c. LOCATION — City or Town, State                                                         |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Ronald Wade, Dir</i>                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>State Anatomy Board</b><br><b>655W. Baltimore St, Balto, MD 21201</b>                                                                                    |  |                                                                                             |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Parkinson's Disease</b>                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| a. DUE TO (OR AS A CONSEQUENCE OF): <b>HTN</b>                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| b. DUE TO (OR AS A CONSEQUENCE OF): <b>Diabetic Mellitus</b>                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Decubitus ulcer</b>                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined                                                                                                                                                |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                            |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                         |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                    |  |                                                                                             |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Samuel Chan</i>                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>D36655</b>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>Nov. 14, 1994</b>                                 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Samuel Chan, M.D. 1185 Mt. Aetna Road, Hagerstown, MD 21740</b>                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  | 32. REGISTRAR'S SIGNATURE<br><i>Richard</i>                                                                                                                                                     |  |                                                                                             |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Feb 1951

RECEIVED

7-20-51

RECEIVED

7-20-51



94 33898

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                         |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Joseph Davis</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH <i>11</i> DAY <i>16</i> YEAR <i>94</i>                                                                                                                                |  | 3. TIME OF DEATH<br><i>1235 A M</i>                                                                                                     |  |
| 4. SOCIAL SECURITY NUMBER<br><i>236229545</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><i>71</i> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><i>03-28-23</i>                                                                                  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>VA MEDICAL CENTER</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>BALTIMORE</i>                                                                                                                                         |  | 9c. COUNTY OF DEATH<br><i>VA</i>                                                                                                        |  |
| 10a. STATE<br><i>MD</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  | 10b. COUNTY                                                                                                                                                                                     |  | 10c. CITY, TOWN OR LOCATION<br><i>BALTIMORE CITY</i>                                                                                    |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                         |  |
| 10e. STREET AND NUMBER<br><i>1109 N. MONTFORD AVE</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  | 10f. ZIP CODE<br><i>21213</i>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>                                                                                          |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><i>WWII</i>                                                                                                                                    |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><i>BLACK</i>                                                              |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input checked="" type="checkbox"/> College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>UNEMPLOYED</i>                                                                                                                                                             |  | 16b. KIND OF BUSINESS/INDUSTRY                                                                                                                                                                  |  |                                                                                                                                         |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>JOHN DAVIS</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>CHANNIE COX</i>                                                                                                                         |  |                                                                                                                                         |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>ROSA MCCORMICK</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>1109 N. MONTFORD AVE BALTO, MD. 21213</i>                                                   |  |                                                                                                                                         |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>GARRISON FOREST VA 11/21</i>                                                                                                                                                                             |  | 20c. LOCATION — City or Town, State<br><i>OWINGS MILLS, MD.</i>                                                                                                                                 |  |                                                                                                                                         |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSE<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><i>BETTS FUNERAL HOOME<br/>1129 N. CAROLINE ST. BALTO, MD 21213</i>                                                                                         |  |                                                                                                                                         |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Multisystem Organ Failure</i><br>Approximate Interval Between Onset and Death <i>1 week</i><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>a. <i>Interabdominal Sepsis</i> DUE TO (OR AS A CONSEQUENCE OF): <i>2 weeks</i><br>b. <i>Enterocutaneous Fistula</i> DUE TO (OR AS A CONSEQUENCE OF): <i>1 month</i><br>c. <i>Right Hemiparesis</i> DUE TO (OR AS A CONSEQUENCE OF): <i>2 months</i><br>d. |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                         |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                         |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                                                         |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><i>M</i>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                        |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                          |  |                                                                                                                                         |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                         |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                         |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER                                                                                                                                                                             |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>11/16/94</i>                                                                                  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>David Szymon MD 22 S. Green St Baltimore, MD 21230</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                         |  |
| 31. DATE FILED (Month, Day, Year)<br><i>NOV 18 1994</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                                                                                                 |  |                                                                                                                                         |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33899

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                               |  |                                                                                                                                                          |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ERNESTINE DUPREE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH <b>11-17</b> DAY <b>1994</b> YEAR <b>12:23 A.M.</b>                                                                                                                 |  | 3. TIME OF DEATH<br><b>12:23 A.M.</b>                                                                                                                    |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-09-9993</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>82</b> YRS.                                                                                                                                              |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>04/02/12</b>                                                                                                   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>SINAI HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>                                                                                                                                  |  | 9c. COUNTY OF DEATH<br><b>VA</b>                                                                                                                         |  |
| 10a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 10b. COUNTY<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>                                                                                                                                               |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                          |  |
| 10e. STREET AND NUMBER<br><b>2 ALBESS CT APT 201</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  | 10f. ZIP CODE<br><b>21133</b>                                                                                                                                                                 |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                           |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                              |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b>                                                                               |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input checked="" type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                             |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOUSEWIFE</b>                                                                                                                                                                 |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>HOME</b>                                                                                                                                                 |  |                                                                                                                                                          |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>GEORGE W. BREWER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>HENREITTA WYNN</b>                                                                                                                    |  |                                                                                                                                                          |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>ESTELLE HATTON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1817 BARCLAY ST. BALTO., MD. @!@21202</b>                                                 |  |                                                                                                                                                          |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                       |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>DRUID RIDGE CEMETERY</b>                                                                                                                                                                                 |  | 20c. LOCATION — City or Town, State<br><b>11/22 PIKESVILLE, MD.</b>                                                                                                                           |  | 20d. DATE<br><b>11/22</b>                                                                                                                                |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Guadalupe Comantia</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>BETTS FUNERAL HOME</b><br><b>1129 N. CAROLINE ST. BALTO, MD 21213</b>                                                                                  |  |                                                                                                                                                          |  |
| 23. PART I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. <b>SEPSIS</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>ASPIRATION PNEUMONIA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>METASTATIC CANCER 2<sup>nd</sup> TO PRIMARY BREAST CANCER</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. <b>SEIZURES</b> |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                               |  | Approximate Interval Between Onset and Death                                                                                                             |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                               |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                    |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                               |  | 24c. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                               |  |                                                                                                                                                          |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                   |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                             |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                         |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                         |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                  |  |                                                                                                                                                          |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                               |  |                                                                                                                                                          |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Isabel C. Borrás MD</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>2402321</b>                                                                                                                                                         |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/17/94</b>                                                                                                   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>ISABEL C. BORRAS SINAI HOSPITAL BALTIMORE MD 29201</b>                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                               |  |                                                                                                                                                          |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  | 32. REGISTRAR'S SIGNATURE<br><i>John S. ...</i>                                                                                                                                               |  |                                                                                                                                                          |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94-6538-510

DWG

Item#15,16a,22 Per F.H. 11/18/94 Film# G#717 R.M.

94 33900

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                                                                           |                                                  |                                                                                                                                                                                                                 |  |                                                                                                                   |                                                                                                                         |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>TIMOTHY DAVIS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                                                           |                                                  | 2. DATE OF DEATH<br>MONTH <b>NOV.</b> DAY <b>10</b> YEAR <b>94</b>                                                                                                                                              |  | 3. TIME OF DEATH<br><b>9:35 P M</b>                                                                               |                                                                                                                         |
| 4. SOCIAL SECURITY NUMBER<br><b>212-92-8277</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 5. SEX<br><b>1</b> <input checked="" type="checkbox"/> M <b>2</b> <input type="checkbox"/> F                                                                                                                                                                                                                                                                              | 6. AGE (In yrs. last birthday)<br><b>17</b> YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br><b>October 10, 1977</b>                                                                                                                                                  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                                                       |                                                                                                                         |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>1058 ARGYLE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                                                                           |                                                  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>                                                                                                                                                    |  | 9c. COUNTY OF DEATH                                                                                               |                                                                                                                         |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                                                           |                                                  |                                                                                                                                                                                                                 |  |                                                                                                                   |                                                                                                                         |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 10b. COUNTY                                                                                                                                                                                                                                                                                                                                                               |                                                  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                                                                                                                                                                 |  | 10d. INSIDE CITY LIMITS?<br><b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO |                                                                                                                         |
| 10e. STREET AND NUMBER<br><b>1500 Pennsylvania Avenue</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                                                                           |                                                  | 10f. ZIP CODE<br><b>21217</b>                                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                       |                                                                                                                         |
| 11. MARITAL STATUS<br><b>1</b> <input checked="" type="checkbox"/> Never Married <b>2</b> <input type="checkbox"/> Married<br><b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                 |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                            |                                                  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                                           |                                                                                                                         |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>1 YR. College</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>NONE</b>                                                                                                                                                                                                                                                 |                                                  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>None</b>                                                                                                                                                                   |  |                                                                                                                   |                                                                                                                         |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Timothy D. Davis Sr.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                           |                                                  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Linda Goodman</b>                                                                                                                                       |  |                                                                                                                   |                                                                                                                         |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Linda Goodman</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                                                                                           |                                                  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1500 Pennsylvania Ave. Baltimore MD. 21217</b>                                                              |  |                                                                                                                   |                                                                                                                         |
| 20a. METHOD OF DISPOSITION<br><b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State<br><b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                 |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>King Memorial Park</b>                                                                                                                                                                                                                                                              |                                                  | DATE<br><b>11/17</b>                                                                                                                                                                                            |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Maryland</b>                                                 |                                                                                                                         |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Kevin Parker</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                                                           |                                                  | 22. NAME AND ADDRESS OF FACILITY<br><b>Nutter Funeral Home Inc.<br/>2501m Gwynn Falls Pky. Baltimore, Md. 21216<br/>2501 GWYNN FALLS PKY.</b>                                                                   |  |                                                                                                                   |                                                                                                                         |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Multiple Gunshot Wounds</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                                                                                                                                                                                                           |                                                  |                                                                                                                                                                                                                 |  |                                                                                                                   | Approximate Interval Between Onset and Death                                                                            |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                           |                                                  |                                                                                                                                                                                                                 |  |                                                                                                                   | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                                                                           |                                                  |                                                                                                                                                                                                                 |  |                                                                                                                   |                                                                                                                         |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                                                                           |                                                  |                                                                                                                                                                                                                 |  |                                                                                                                   |                                                                                                                         |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA<br>OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input checked="" type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify) <b>ON THE STREET</b> |                                                  |                                                                                                                                                                                                                 |  |                                                                                                                   |                                                                                                                         |
| 27. MANNER OF DEATH<br><b>1</b> <input type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation<br><b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined<br><b>3</b> <input type="checkbox"/> Suicide <b>8</b> <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                           |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>11/10/94</b>                                                                                                                                                                                                                                                                                                                 |                                                  | 28b. TIME OF INJURY<br><b>2125HRS</b>                                                                                                                                                                           |  | 28c. INJURY AT WORK?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO     |                                                                                                                         |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>Roadway</b>                                                                                                                                                                                                                                                                  |                                                  | 28e. DESCRIBE HOW INJURY OCCURRED<br><b>subject shot</b>                                                                                                                                                        |  |                                                                                                                   |                                                                                                                         |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>1058 Argyle Maryland</b>                                                                                                                                                                                                                                                               |                                                  |                                                                                                                                                                                                                 |  |                                                                                                                   |                                                                                                                         |
| 29a. CERTIFIER (Check only one)<br><b>2</b> <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                                           |                                                  |                                                                                                                                                                                                                 |  |                                                                                                                   |                                                                                                                         |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Theodore M. King, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                           |                                                  | 29c. LICENSE NUMBER<br><b>O.C.M.E.</b>                                                                                                                                                                          |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>NOV. 11/94</b>                                                          |                                                                                                                         |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Theodore M. King 111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                                                                           |                                                  |                                                                                                                                                                                                                 |  |                                                                                                                   |                                                                                                                         |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 32. REGISTRAR'S SIGNATURE<br><b>J. Anderson</b>                                                                                                                                                                                                                                                                                                                           |                                                  |                                                                                                                                                                                                                 |  |                                                                                                                   |                                                                                                                         |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33901

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                           |  |                                                                                                 |                                                                                                                                                    |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>CHARLES EDGAR DUNLAP</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                 |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 17, 1994</b>                                                                                                                                                                                                                            |  | 3. TIME OF DEATH<br>M<br><b>M</b>                                                               |                                                                                                                                                    |
| 4. SOCIAL SECURITY NUMBER<br><b>218-28-7478</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                      |  | 6. AGE (In yrs. last birthday)<br><b>61</b> YRS.                                                                                                                                                                                                                                          |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>June 8, 1933</b>                                   |                                                                                                                                                    |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                 |  | 9. COUNTY OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                    |  |                                                                                                 |                                                                                                                                                    |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>1206 Westerlee Place Apt 2B</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                 |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>B</b>                                                                                                                                                                                                                                           |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>                                                         |                                                                                                                                                    |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 10b. COUNTY<br><b>Baltimore</b>                                                                                                                 |  | 10c. CITY, TOWN OR LOCATION<br><b>Catonsville</b>                                                                                                                                                                                                                                         |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |                                                                                                                                                    |
| 10e. STREET AND NUMBER<br><b>1206 Westerlee Place Apt 2B</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                 |  | 10f. ZIP CODE<br><b>21228</b>                                                                                                                                                                                                                                                             |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                     |                                                                                                                                                    |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                           |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>                      |                                                                                                                                                    |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>College 2</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>General Supervisor</b>      |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>U. S. Postal Officer</b>                                                                                                                                                                                                                             |  |                                                                                                 |                                                                                                                                                    |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Perry Dunlap</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                 |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Reba Simpson</b>                                                                                                                                                                                                                  |  |                                                                                                 |                                                                                                                                                    |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Harriet R. Dunlap</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                 |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1206 Westerlee Place Catonsville, Maryland 21228</b>                                                                                                                                  |  |                                                                                                 |                                                                                                                                                    |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Arbutus Memorial Park 11/22 Baltimore County, MD</b>      |  | 20c. LOCATION — City or Town, State                                                                                                                                                                                                                                                       |  | 20d. LOCATION — City or Town, State                                                             |                                                                                                                                                    |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>John J. Hollens</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                 |  | 22. NAME AND ADDRESS OF FACILITY<br><b>NUTTER FUNERAL HOMES, INC.<br/>2501 GWYNNS FALLS PARKWAY BALTO, MD 21211</b>                                                                                                                                                                       |  |                                                                                                 |                                                                                                                                                    |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Respiratory Failure</b><br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. <b>Respiratory Failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>Encephalopathy</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>AIDS</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                           |  |                                                                                                 | Approximate Interval Between Onset and Death<br><b>minutes</b><br><br><b>2 months</b>                                                              |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                           |  |                                                                                                 | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                              |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                           |  |                                                                                                 | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                 |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide |  | 28a. DATE OF INJURY (Month, Day, Year)                                                          |                                                                                                                                                    |
| 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                     |  | 28d. DESCRIBE NOW INJURY OCCURRED                                                                                                                                                                                                                                                         |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |                                                                                                                                                    |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                  |  |                                                                                                                                                 |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Steven C. Miller, MD</i>                                                                                                                                                                                                                      |  | 29c. LICENSE NUMBER<br><b>043152</b>                                                            |                                                                                                                                                    |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>11/17/94</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                 |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Steven C. Miller 1717 Gwynn Oak Ave Balto, MD 21207</b>                                                                                                                                         |  |                                                                                                 |                                                                                                                                                    |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                 |  | 32. REGISTRAR'S SIGNATURE<br><i>John J. Hollens</i>                                                                                                                                                                                                                                       |  |                                                                                                 |                                                                                                                                                    |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





94 33902

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                        |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>CHARLES DAMON</b>                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                     |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 7 1994</b>                                                                                                                                                                                                                                               |  | 3. TIME OF DEATH<br><b>7:15 P. M.</b>                                                                                                                  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>215-03-8840</b>                                                                                                                                                                                                                                                                                                                                                                                  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                          |  | 6. AGE (In yrs. last birthday)<br><b>91 YRS.</b>                                                                                                                                                                                                                                                           |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>October 19, 1903</b>                                                                                         |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>UNION MEMORIAL HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                     |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>                                                                                                                                                                                                                                               |  | 9c. COUNTY OF DEATH                                                                                                                                    |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                        |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  | 10b. COUNTY                                                                                                                                         |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                                                                                                                                                                                                                                                            |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                        |  |
| 10e. STREET AND NUMBER<br><b>11 W. 20th Street Apt. 18-g</b>                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                     |  | 10f. ZIP CODE<br><b>21218</b>                                                                                                                                                                                                                                                                              |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                            |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                           |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                                                                                                        |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>                                                                             |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>Unknown</b><br>College (1-4 or 5+) <b>Unknown</b>                                                                                                                                                                                                                                                                           |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Unknown</b>                     |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Unknown</b>                                                                                                                                                                                                                                                           |  |                                                                                                                                                        |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Unknown</b>                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                     |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Unknown</b>                                                                                                                                                                                                                                        |  |                                                                                                                                                        |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Father James Manning</b>                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                     |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)                                                                                                                                                                                                              |  |                                                                                                                                                        |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metro Crematory</b>                                           |  | 20c. LOCATION — City or Town, State<br><b>11/15 Baltimore, Maryland</b>                                                                                                                                                                                                                                    |  | 20d. DATE<br><b>11/15</b>                                                                                                                              |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Kevin Parker</b>                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                     |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Nutter Funeral Home Inc.<br/>2501 Gwyn Falls PKY. Baltimore, Maryland 21216</b>                                                                                                                                                                                     |  |                                                                                                                                                        |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                        |  |                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                        |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Anoxic Encephalopathy</b>                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                        |  |
| b. <b>Left CVA</b>                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                        |  |
| c. <b>Left CVA</b>                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                        |  |
| d. <b>Left CVA</b>                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                        |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                       |  |                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                        |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension, Diabetes Mellitus, Coronary artery disease</b>                                                                                                                                                                                                                                        |  |                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                        |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                        |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                     |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                        |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                        |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                              |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                                                                                                                            |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                   |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                     |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                          |  |                                                                                                                                                        |  |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                     |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                               |  |                                                                                                                                                        |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                        |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Resident</b>                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                     |  | 29c. LICENSE NUMBER<br><b>P08049</b>                                                                                                                                                                                                                                                                       |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/07/94</b>                                                                                                 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>ASAD, FARHANA</b>                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                        |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                     |  | 32. REGISTRAR'S SIGNATURE<br><b>Jebi Anderson</b>                                                                                                                                                                                                                                                          |  |                                                                                                                                                        |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33903

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                             |                                                                                                       |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Bryan McKinley Drummond</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                           |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov. 16 94</b>                                                                                                                                                                                                                                                                                                                                                                      |  | 3. TIME OF DEATH<br><b>5:45 AM</b>                                                          |                                                                                                       |
| 4. SOCIAL SECURITY NUMBER<br><b>213-80-5738</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                                |  | 6. AGE (In yrs., last birthday)<br><b>35</b> YRS.                                                                                                                                                                                                                                                                                                                                                                            |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Sept. 12, 1959</b>                                |                                                                                                       |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                           |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>1226 W. Lafayette Avenue</b>                                                                                                                                                                                                                                                                                                                            |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>                                     |                                                                                                       |
| 9c. COUNTY OF DEATH<br><b>N/A</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                           |  | 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                |  | 10b. COUNTY<br><b>N/A</b>                                                                   |                                                                                                       |
| 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                           |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                              |  | 10e. STREET AND NUMBER<br><b>1226 W. Lafayette Avenue</b>                                   |                                                                                                       |
| 10f. ZIP CODE<br><b>21217</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                           |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                             |                                                                                                       |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                              |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                              |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                     |                                                                                                       |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 4+                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Counselor</b>                                                                                                                                                                         |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Washington, D.C. Public School System</b>                                                                                                                                                                                                                                                                                                                                               |  |                                                                                             |                                                                                                       |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Leroy Drummond</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                           |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Lorraine R. Booker</b>                                                                                                                                                                                                                                                                                                                                               |  |                                                                                             |                                                                                                       |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Lorraine R. Drummond</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Apt. 304<br/>6602 Vincient Lane Baltimore, Md 21215</b>                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                             |                                                                                                       |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>King Memorial Park</b>                                                                                                                                                                                              |  | 20c. DATE<br><b>11/19/94</b>                                                                                                                                                                                                                                                                                                                                                                                                 |  | 20d. LOCATION — City or Town, State<br><b>Randallstown, Maryland</b>                        |                                                                                                       |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                           |  | 22. NAME AND ADDRESS OF FACILITY<br><b>5240 Reisterstown Rd<br/>Chatman-Harris F/H Baltimore, Md 21215</b>                                                                                                                                                                                                                                                                                                                   |  |                                                                                             |                                                                                                       |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>AIDS ENCEPHALOPATHY</b><br>DUE TO (OR AS A CONSEQUENCE OF): <b>LEUCOPENIA</b><br>DUE TO (OR AS A CONSEQUENCE OF): <b>ANEMIA</b><br>DUE TO (OR AS A CONSEQUENCE OF): <b>HEPATITIS AIDS INDUCED</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>Metabolic Imbalance</b> |  |                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                             | Approximate interval Between Onset and Death                                                          |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Metabolic Imbalance</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                             | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                             |                                                                                                       |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                             |                                                                                                       |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                             |                                                                                                       |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                   |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                    |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                              |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |                                                                                                       |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                           |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                       |  |                                                                                             |                                                                                                       |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                           |  | 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                             |                                                                                                       |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i> MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                           |  | 29c. LICENSE NUMBER<br><b>D25755</b>                                                                                                                                                                                                                                                                                                                                                                                         |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/16/94</b>                                      |                                                                                                       |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>ROBERTA J WILLIAMS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                             |                                                                                                       |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                             |                                                                                                       |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33904

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  |                                                                            |                                                                              |                                                                                                 |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------|------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>SALLY ELLIS</b>                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 10, 1994</b>             |                                                                              | 3. TIME OF DEATH<br><b>9:30 P M</b>                                                             |  |
| 4. SOCIAL SECURITY NUMBER<br><b>159-01-6181</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                   |  | 6. AGE (In yrs. last birthday)<br><b>92</b> YRS.                                                                                                                                                                                                                                            |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Jan. 19, 1902</b>                |                                                                              | 8. BIRTHPLACE (State or Foreign Country)<br><b>Russia</b>                                       |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Manor Care Silver Spring</b>                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Silver Spring</b>                |                                                                              | 9c. COUNTY OF DEATH<br><b>Montgomery</b>                                                        |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  |                                                                            |                                                                              |                                                                                                 |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                |  | 10b. COUNTY<br><b>Howard</b>                                                                                                                 |  | 10c. CITY, TOWN OR LOCATION<br><b>Ellicott City</b>                                                                                                                                                                                                                                         |  |                                                                            |                                                                              | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>9808 Woodbridge Court</b>                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                              |  | 10f. ZIP CODE<br><b>21042</b>                                                                                                                                                                                                                                                               |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                |                                                                              |                                                                                                 |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                               |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                             |  |                                                                            | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>      |                                                                                                 |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (9-12) <b>12</b> College (1-4 or 5+) <b></b>                                                                                                                                                                                                                                                                                         |  |                                                                                                                                              |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Bookkeeper</b>                                                                                                                                                             |  |                                                                            | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Vacuum Cleaner Co.</b>                  |                                                                                                 |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Kasel Machington</b>                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Bess (Unknown)</b> |                                                                              |                                                                                                 |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Dr. Kenneth R. Ellis</b>                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                              |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9808 Woodbridge Court, Ellicott City, Maryland 21042</b>                                                                                                                                |  |                                                                            |                                                                              |                                                                                                 |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |  |                                                                                                                                              |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Montefiore Cemetery 11/13/1994</b>                                                                                                                                                                             |  |                                                                            | 20c. LOCATION — City or Town, State<br><b>Abington, Pennsylvania</b>         |                                                                                                 |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Donald C. Stottmeyer</b>                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                              |  | 22. NAME AND ADDRESS OF FACILITY<br><b>STEIN HEBREW MEMORIAL FUNERAL HOME, INC.<br/>232 CARROLL STREET, NW, WASHINGTON, DC 20012</b>                                                                                                                                                        |  |                                                                            |                                                                              |                                                                                                 |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                    |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  |                                                                            |                                                                              |                                                                                                 |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. CARDIOPULMONARY ARREST</b>                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  |                                                                            |                                                                              |                                                                                                 |  |
| DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  |                                                                            |                                                                              |                                                                                                 |  |
| b. <b>CAD</b>                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  |                                                                            |                                                                              |                                                                                                 |  |
| DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  |                                                                            |                                                                              |                                                                                                 |  |
| c. <b>COPE</b>                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  |                                                                            |                                                                              |                                                                                                 |  |
| DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  |                                                                            |                                                                              |                                                                                                 |  |
| d. <b>DEMENTIA</b>                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  |                                                                            |                                                                              |                                                                                                 |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  |                                                                            |                                                                              |                                                                                                 |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                              |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                            |                                                                              |                                                                                                 |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide                                                                                                                                                |  |                                                                                                                                              |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                      |  | 28b. TIME OF INJURY<br><b>M</b>                                            |                                                                              | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                              |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                           |  |                                                                            | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) |                                                                                                 |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  |                                                                            |                                                                              |                                                                                                 |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>HARVEY OGG</b>                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                              |  | 29c. LICENSE NUMBER<br><b>3D1172</b>                                                                                                                                                                                                                                                        |  |                                                                            | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/11/94</b>                       |                                                                                                 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>HARVEY OGG MD 3468 ELICOTT CITY DR 183 EL MD 21042</b>                                                                                                                                                                                                                                                                             |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  |                                                                            |                                                                              |                                                                                                 |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                              |  | 32. REGISTRAR'S SIGNATURE<br><b>John A. ...</b>                                                                                                                                                                                                                                             |  |                                                                            |                                                                              |                                                                                                 |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

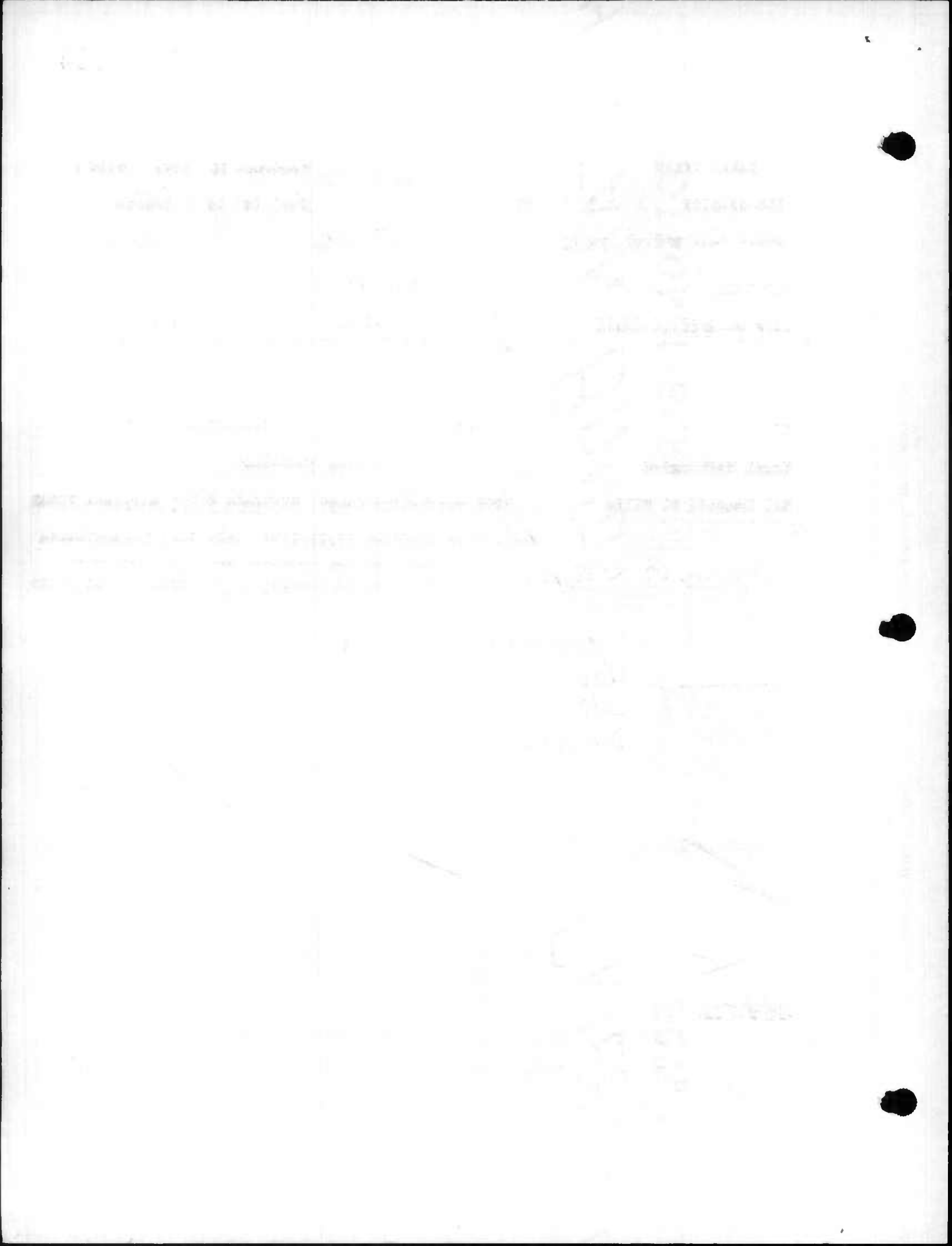
BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33905

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                |                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                       |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Burton W Elburn</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |                                                  | 2. DATE OF DEATH<br>MONTH <b>November</b> DAY <b>13</b> YEAR <b>1994</b>                                                                                                       |                                                  | 3. TIME OF DEATH<br><b>7:00 PM</b>                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                       |
| 4. SOCIAL SECURITY NUMBER<br><b>218-26-3522</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     | 6. AGE (In yrs. last birthday)<br><b>63</b> YRS. | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>                                                                                                                               | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b> | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>10-29-31</b>                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                       |
| 8a. FACILITY NAME (If not institution, give street and number)<br><b>Union Memorial Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |                                                  | 8b. CITY, TOWN OR LOCATION OF DEATH<br><b>Balto City</b>                                                                                                                       |                                                  | 8c. COUNTY OF DEATH<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                       |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |                                                  | 10b. COUNTY<br><b>Baltimore</b>                                                                                                                                                |                                                  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                       |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |                                                  | 10e. STREET AND NUMBER<br><b>3003 N. Charles Street</b>                                                                                                                        |                                                  | 10f. ZIP CODE<br><b>21218</b>                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                       |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |                                                  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced |                                                  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                                     |                                                                                                       |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |                                                  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>white</b>                                                                                                     |                                                  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>                                                                                                                                                                                                                                                                                   |                                                                                                       |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housekeeping Supervisor</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |                                                  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Johns Hopkins University</b>                                                                                                              |                                                  | 17. FATHER'S NAME (First, Middle, Last)<br><b>Burton Elburn</b>                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                       |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Gertrude Piechaicki</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |                                                  | 19a. INFORMANT'S NAME (Type/Print)<br><b>Joan Elburn</b>                                                                                                                       |                                                  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8666 Park Dr. Chestertown, MD 21620</b>                                                                                                                                                                                                                                                                                      |                                                                                                       |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |                                                  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Wesley Chapel Cem. 11/17</b>                                                             |                                                  | 20c. LOCATION — City or Town, State<br><b>Rock Hall, Maryland</b>                                                                                                                                                                                                                                                                                                                                                                |                                                                                                       |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Lacy Henss</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |                                                  | 22. NAME AND ADDRESS OF FACILITY<br><b>Burgee-Henss Funeral Home<br/>3631 Falls Rd Balto., MD 21211</b>                                                                        |                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                       |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. <b>Acute severe pneumonia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                |                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                  | Approximate Interval Between Onset and Death<br><b>3 days</b>                                         |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Asymptomatic lateral sclerosis</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                |                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                |                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                       |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                |                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                       |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                  |                                                                                                                                                                                |                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                       |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                      |  | 28a. DATE OF INJURY<br>(Month, Day, Year)                                                                                                                                                                                                                                                      |                                                  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                |                                                  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                      |                                                                                                       |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                         |                                                  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                   |                                                  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                                                                       |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Natesan</i> <b>Dr. NATESAN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 29c. LICENSE NUMBER<br><b>AT 243-P946 E16</b>                                                                                                                                                                                                                                                  |                                                  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/13/94</b>                                                                                                                         |                                                  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Union Memorial Hospital Dr. Velmourougane Natesan</b>                                                                                                                                                                                                                                                                                  |                                                                                                       |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 32. REGISTRAR'S SIGNATURE<br><i>John A. Hudson</i>                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                |                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                       |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 -  
FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                             |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Catherine M. Eburg                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>11-16-1994                                                                                                                                                                                                                                                           |  | 3. TIME OF DEATH<br>7:20 P M                                                                                                                |  |
| 4. SOCIAL SECURITY NUMBER<br>220-18-4302                                                                                                                                                                                                                                                                                                                                                                                         |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                   |  | 6. AGE (In yrs. last birthday)<br>79 YRS.                                                                                                                                                                                                                                                                  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>12-13-14                                                                                             |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>KESWICK Home                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore                                                                                                                                                                                                                                                           |  | 9c. COUNTY OF DEATH<br>--                                                                                                                   |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                             |  |
| 10a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                           |  | 10b. COUNTY<br>--                                                                                                                                |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore                                                                                                                                                                                                                                                                   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                         |  |
| 10e. STREET AND NUMBER<br>700 W. 40th Street                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                  |  | 10f. ZIP CODE<br>21211                                                                                                                                                                                                                                                                                     |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                        |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                           |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                                                                                                        |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: white                                                                            |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8th College (1-4 or 5+) --                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Accounting                                                                                                                                                                                   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Reed's Drug Store                                                                                         |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Thomas F. Mooney, Sr.                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Amelia Elliott                                                                                                                                                                                                                                        |  |                                                                                                                                             |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Edwin L. Rinehart                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                  |  | 19b. MAILING ADDRESS (Street and Number, City or Town, State, Zip Code)<br>PO BOX 173 GLYNDON, Maryland 21071                                                                                                                                                                                              |  |                                                                                                                                             |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) Entombment                                                                                                                                                                       |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Druid Ridge Cemetery 11/19                                    |  | 20c. LOCATION — City or Town, State<br>Pikesville, MD                                                                                                                                                                                                                                                      |  |                                                                                                                                             |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Tracy H. Carpenter</i>                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                  |  | 22. NAME AND ADDRESS OF FACILITY<br>Burgee-Henss Funeral Home<br>3631 Falls Road Balto., MD 21211                                                                                                                                                                                                          |  |                                                                                                                                             |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                        |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                             |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Atherosclerotic Cardio-vascular disease</i>                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                             |  |
| a. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                             |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                             |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                             |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                             |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                       |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                             |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Dementia illness consistent with Alzheimer's disease</i>                                                                                                                                                                                                                                            |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                             |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                             |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                             |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                           |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                           |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                                                                                                                                   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                        |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                  |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                          |  |                                                                                                                                             |  |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                             |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                             |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>M. Isabelle Mac Gregor MD</i>                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                  |  | 29c. LICENSE NUMBER<br>D13657                                                                                                                                                                                                                                                                              |  | 29d. DATE SIGNED (Month, Day, Year)<br>November 18, 1994                                                                                    |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>M. ISABELLE MAC GREGOR, KESWICK, 700 W. 40th ST. BALTO. MD 21211                                                                                                                                                                                                                                                                          |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                             |  |
| 31. DATE FILED (Month, Day, Year)<br>NOV 18 1994                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                  |  | 32. REGISTRAR'S SIGNATURE<br><i>John A. ...</i>                                                                                                                                                                                                                                                            |  |                                                                                                                                             |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33907

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MILDRED JULIA FALTER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                               |  | 2. DATE OF DEATH<br>MONTH <b>NOV.</b> DAY <b>10</b> YEAR <b>1994</b>                                                                                                                            |  | 3. TIME OF DEATH<br><b>8:00 P.M.</b>                                                            |                                                                                                       |
| 4. SOCIAL SECURITY NUMBER<br><b>218-14-8920</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                                    |  | 6. AGE (In yrs. last birthday)<br><b>69</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>APR 15, 1925</b>                                      |                                                                                                       |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>STELLA MARIS Hospice</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                               |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Towson</b>                                                                                                                                            |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>                                                         |                                                                                                       |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 10b. COUNTY<br><b>Baltimore</b>                                                                                                                                                                                                                                                                               |  | 10c. CITY, TOWN OR LOCATION<br><b>PARKVILLE</b>                                                                                                                                                 |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |                                                                                                       |
| 10e. STREET AND NUMBER<br><b>2465 Ellis Road</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                               |  | 10f. ZIP CODE<br><b>21234</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                  |                                                                                                       |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                             |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>                      |                                                                                                       |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 YRS.</b><br>College (1-4 or 5+) <b>College</b>                                                                                                                                                                                                                                                                                                                                                                                                     |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Customer Service Rep.</b>                                                                                                                                                                 |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Baltimore Gas + Electric</b>                                                                                                                               |  |                                                                                                 |                                                                                                       |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JAMES DOYLE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                               |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>LOITH MURBACH</b>                                                                                                                       |  |                                                                                                 |                                                                                                       |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>DANIEL J. FALTER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                               |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3226 TEXAS AVE PARKVILLE, MARYLAND 21234</b>                                                |  |                                                                                                 |                                                                                                       |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                      |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>GESSA MOUNT CREMATORY 11-14-94</b>                                                                                                                                                                                      |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Maryland</b>                                                                                                                               |  |                                                                                                 |                                                                                                       |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                               |  | 22. NAME AND ADDRESS OF FACILITY<br><b>EVANS CHAPEL OF MEMORIES<br/>8800 HARFORD ROAD - PARKVILLE</b>                                                                                           |  |                                                                                                 |                                                                                                       |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CANCER OF PANCREAS</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>a. _____<br>b. _____<br>c. _____<br>d. _____<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                 |  |                                                                                                 | Approximate Interval Between Onset and Death                                                          |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                 |  |                                                                                                 | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 28. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>HOSPICE</b> |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                 |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                        |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |                                                                                                       |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                               |  | 28e. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                               |  |                                                                                                 |                                                                                                       |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                               |  |                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Kendall Faulkner</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                               |  | 29c. LICENSE NUMBER<br><b>D25643</b>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/11/94</b>                                          |                                                                                                       |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DR. KENDALL FAULKNER 2300 DULANEY VALLEY RD., TOWSON, MD 21204</b>                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                               |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                   |  |                                                                                                 |                                                                                                       |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33908

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Guy Fielden, Sr.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                 |  | 2. DATE OF DEATH<br>MONTH <b>November</b> DAY <b>13</b> YEAR <b>1994</b>                                                                                                                            |  | 3. TIME OF DEATH<br><b>M</b>                                                                        |                                                                                                |
| 4. SOCIAL SECURITY NUMBER<br><b>266-18-8873</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                                                                                                                                                  |  | 8. AGE (In yrs. last birthday)<br><b>78</b> YRS.                                                                                                                                                    |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>April 23, 1916</b>                                        |                                                                                                |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>231 Kilgore Court</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Joppatown</b>                                                                                                                                                                                                                                         |  | 9c. COUNTY OF DEATH<br><b>Harford Co.</b>                                                                                                                                                           |  |                                                                                                     |                                                                                                |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 10b. COUNTY<br><b>Baltimore</b>                                                                                                                                                                                                                                                                 |  | 10c. CITY, TOWN OR LOCATION<br><b>Dundalk</b>                                                                                                                                                       |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |                                                                                                |
| 10e. STREET AND NUMBER<br><b>7512 Lawrence Road</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                 |  | 10f. ZIP CODE<br><b>21222</b>                                                                                                                                                                       |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                                               |                                                                                                |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                             |                                                                                                |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>12 Years</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Mechanic</b>                                                                                                                                                                |  | 15b. KIND OF BUSINESS/INDUSTRY<br><b>Curtis Engine &amp; Equipment</b>                                                                                                                              |  |                                                                                                     |                                                                                                |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Guy Fielden</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                 |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Bertha Ogle</b>                                                                                                                             |  |                                                                                                     |                                                                                                |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs. Thelma E. Fielden</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                 |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7512 Lawrence Road Dundalk, Maryland 21222</b>                                                  |  |                                                                                                     |                                                                                                |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                              |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Meadowridge Mem. Pk. 11/16/94</b>                                                                                                                                                                         |  | 20c. LOCATION — City or Town, State<br><b>Elkridge, MD</b>                                                                                                                                          |  |                                                                                                     |                                                                                                |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Johnny L. Gable</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                 |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Duda-Ruck Funeral Home of Dundalk, Inc.<br/>7922 Wise Ave. Dundalk, Maryland 21222</b>                                                                       |  |                                                                                                     |                                                                                                |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Intestinal colon cancer</b><br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                     |  |                                                                                                     | Approximate interval Between Onset and Death                                                   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                     |  |                                                                                                     | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                               |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                          |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                     |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |                                                                                                |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                 |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                              |  |                                                                                                     |                                                                                                |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>William M</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                 |  | 29c. LICENSE NUMBER<br><b>018558</b>                                                                                                                                                                |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/15/94</b>                                              |                                                                                                |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                 |  | 32. REGISTRAR'S SIGNATURE<br><i>John A. Anderson</i>                                                                                                                                                |  |                                                                                                     |                                                                                                |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33909

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>George Felton</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov. 16, 1994</b>                                                                                                                                      |  | 3. TIME OF DEATH<br>HOURS MIN. SEC.<br><b>5:30 A M</b>                                          |                                                                                                       |
| 4. SOCIAL SECURITY NUMBER<br><b>214-56-1490</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     |  | 8. AGE (In yrs. last birthday)<br><b>46</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>09-10-48</b>                                       |                                                                                                       |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>MARYLAND GENERAL HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>                                                                                                                                    |  | 9c. COUNTY OF DEATH<br><b>Maryland</b>                                                          |                                                                                                       |
| 10a. STATE<br><b>MD.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 10b. COUNTY<br><b>AA.CO.</b>                                                                                                                                                                                                                                                                   |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTO., MD.</b>                                                                                                                                               |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |                                                                                                       |
| 10e. STREET AND NUMBER<br><b>200 Key Avenue</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  | 10f. ZIP CODE<br><b>21225</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                  |                                                                                                       |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>                      |                                                                                                       |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Self-employed</b>                                                                                                                                                          |  | 16b. KIND OF BUSINESS/INDUSTRY                                                                                                                                                                  |  |                                                                                                 |                                                                                                       |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>George W. Felton</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Inez Felton</b>                                                                                                                         |  |                                                                                                 |                                                                                                       |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Benjamin L. Felton</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>200 Key Avenue, Balto., MD., 21225</b>                                                      |  |                                                                                                 |                                                                                                       |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Cedar Hill 11/19 Brooklyn, MD.</b>                                                                                                                                                                       |  | 20c. LOCATION — City or Town, State                                                                                                                                                             |  |                                                                                                 |                                                                                                       |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>William C. Brown Community F/H<br/>1206 W. North Ave. Balto., Md</b>                                                                                     |  |                                                                                                 |                                                                                                       |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><b>a. Respiratory Failure - due to Chronic Renal Failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>AIDS</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>b. DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>c. DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>d. DUE TO (OR AS A CONSEQUENCE OF):</b> |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 | Approximate Interval Between Onset and Death<br><b>unknown</b>                                        |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                        |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |                                                                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                              |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                          |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |                                                                                                       |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Tatiana Mouravskaja, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>89224</b>                                                                                                                                                             |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11-16-94</b>                                          |                                                                                                       |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Tatiana Mouravskaja, M.D. c.o Maryland General Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                |  |                                                                                                 |                                                                                                       |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





94 33910

Item#4 Per F.H. Film#717 11/18/94 R.M.

1 -  
FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                 |                                                                                             |                                                                                                                                                    |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JESSE WILLIAM GOODRICH, JR</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                     | 2. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>15</b> YEAR <b>94</b>                                                                                                                                |                                                                                             | 3. TIME OF DEATH<br><b>3:58 P M</b>                                                                                                                |
| 4. SOCIAL SECURITY NUMBER<br><b>219-10-6260</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                          | 6. AGE (In yrs. last birthday)<br><b>68</b> YRS.                                                                                                                                                | 7. DATE OF BIRTH (Month, Day, Year)<br><b>SEPT. 8, 1926</b>                                 |                                                                                                                                                    |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>ST. AGNES HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                     | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>                                                                                                                                         |                                                                                             | 9c. COUNTY OF DEATH<br><b>MARYLAND</b>                                                                                                             |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                 |                                                                                             |                                                                                                                                                    |
| 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 10b. COUNTY<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                     | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>                                                                                                                                                 |                                                                                             | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                    |
| 10e. STREET AND NUMBER<br><b>1801 WOODSIDE AVENUE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                     | 10f. ZIP CODE<br><b>21227</b>                                                                                                                                                                   | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                              |                                                                                                                                                    |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                       | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WW II</b>                                                                                                                        | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |                                                                                             | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>                                                                         |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>3 YEARS</b><br>College (1-4 or 5+) <b>SUPERVISOR</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                     | 16. KIND OF BUSINESS/INDUSTRY<br><b>MANUFACTURING</b>                                                                                                                                           |                                                                                             |                                                                                                                                                    |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JESSE WILLIAM GOODRICH, SR.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                     | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>FLORENCE SALOAN FAULKNER</b>                                                                                                            |                                                                                             |                                                                                                                                                    |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>ANN MAGROGAN GOODRICH</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                     | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1801 WOODSIDE AVENUE - BALTIMORE, MD. 21227</b>                                             |                                                                                             |                                                                                                                                                    |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>MEADOWRIDGE MEMORIAL PARK 11/19</b>                                                                                                                                                           |                                                                                                                                                                                                 | 20c. LOCATION — City or Town, State<br><b>ELKRIDGE</b>                                      |                                                                                                                                                    |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>M. Neaf Coleman</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                     | 22. NAME AND ADDRESS OF FACILITY<br><b>HUBBARD FUNERAL HOME, INC.<br/>4107 WILKENS AVENUE - BALTIMORE, MD 21229</b>                                                                             |                                                                                             |                                                                                                                                                    |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><b>metastatic colon cancer</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><b>renal failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>1 yr 9 months</b><br><b>2 days</b> |                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                 |                                                                                             | Approximate Interval Between Onset and Death                                                                                                       |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                 |                                                                                             | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                              |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                 |                                                                                             | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 28. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                                                                                                                                                 |                                                                                             |                                                                                                                                                    |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural<br>2 <input type="checkbox"/> Accident<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation<br>6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                   | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                              | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                     | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                    |                                                                                             |                                                                                                                                                    |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                 |                                                                                             |                                                                                                                                                    |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Yvonne Ottaviano MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                     | 29c. LICENSE NUMBER<br><b>D40850</b>                                                                                                                                                            | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/15/94</b>                                      |                                                                                                                                                    |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>YVONNE OTTAVIANO, 900 CATON AVE, BALTIMORE MD 21229</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                 |                                                                                             |                                                                                                                                                    |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                     | 32. REGISTRAR'S SIGNATURE<br><b>John Andrew Rodell</b>                                                                                                                                          |                                                                                             |                                                                                                                                                    |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 -  
FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                   |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------|--|
| 1. DECEASED'S NAME (First, Middle, Last) <u>Roena Cheek Grantham</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                              |  | 2. DATE OF DEATH<br>MONTH <u>11</u> DAY <u>14</u> YEAR <u>94</u>                                                                                                                                                                                                                               |  | 3. TIME OF DEATH<br><u>0213</u> M                                                 |  |
| 4. SOCIAL SECURITY NUMBER<br><u>187-07-8752</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                   |  | 6. AGE (In yrs. last birthday)<br><u>84</u> YRS.                                                                                                                                                                                                                                               |  | 7. DATE OF BIRTH (Month, Day, Year)<br><u>2 04 1910</u>                           |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><u>St Agnes Hospital</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                              |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><u>Baltimore</u>                                                                                                                                                                                                                                        |  | 8. BIRTHPLACE (State or Foreign Country)<br><u>N. CAROLINA</u>                    |  |
| 10a. STATE<br><u>Md.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                              |  | 10b. COUNTY                                                                                                                                                                                                                                                                                    |  | 10c. CITY, TOWN OR LOCATION<br><u>Baltimore</u>                                   |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                              |  | 10e. STREET AND NUMBER<br><u>4023 Colborne Road</u>                                                                                                                                                                                                                                            |  |                                                                                   |  |
| 10f. ZIP CODE<br><u>21229</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                              |  | 10g. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                                                                                                                                                                                                                                                 |  |                                                                                   |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify                                                                                                 |  | 14. RACE — American Indian, Black, White, etc.<br>Specify <u>Black</u>            |  |
| 15. DECEASED'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>2</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                              |  | 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><u>Licensed Practical Nurse</u>                                                                                                                                                  |  | 16b. KIND OF BUSINESS/INDUSTRY                                                    |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><u>George W. Cheeks</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                              |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><u>Parlee</u>                                                                                                                                                                                                                             |  |                                                                                   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><u>Theresa Booker</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                              |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>35 VILLA DRIVE, UPPER DUBLINTOWNSHIP (AMBLER PA 19002</u>                                                                                                                                  |  |                                                                                   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                              |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><u>MORRIS Cemetery</u>                                                                                                                                                                                      |  | 20c. LOCATION — City or Town, State<br><u>Phoenixville, Pa.</u>                   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><u>Wm C Brown</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                              |  | 22. NAME AND ADDRESS OF FACILITY<br><u>Wm C Brown F.H. 1206 W. North Ave.</u>                                                                                                                                                                                                                  |  |                                                                                   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Cardiac arrest</u><br>Approximate interval between Onset and Death<br><u>4 days</u><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. <u>Myocardial infarction</u><br>c. <u>Due to (OR AS A CONSEQUENCE OF):</u><br>d. <u>Due to (OR AS A CONSEQUENCE OF):</u> |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Diabetes, hypertension, congestive heart failure</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                              |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                             |  |                                                                                   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                              |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                              |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                              |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                              |  |                                                                                   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                              |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                   |  |                                                                                   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                   |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><u>Dr. Cuoco</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                              |  | 29c. LICENSE NUMBER<br><u>2055</u>                                                                                                                                                                                                                                                             |  | 29d. DATE SIGNED (Month, Day, Year)<br><u>11/14/94</u>                            |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><u>A. Cervone St Agnes Hospital</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                   |  |
| 31. DATE FILED (Month, Day, Year)<br><u>NOV 18 1994</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                              |  | 32. REGISTRAR'S SIGNATURE<br><u>J. H. H. H.</u>                                                                                                                                                                                                                                                |  |                                                                                   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and filed with the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

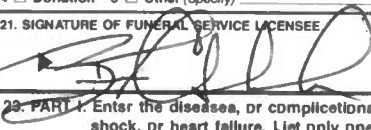

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33912

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                        |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Charlene Elizabeth Gemmill                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>November 8, 1994                                                                                                                                                                                                                                          |  | 3. TIME OF DEATH<br>7:20 PM M                                                                                                                                                          |  |
| 4. SOCIAL SECURITY NUMBER<br>214-56-2518                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>42 YRS.                                                                                                                                                                                                                                                       |  | 7. DATE OF BIRTH (Month, Day, Year)<br>02/21/1952                                                                                                                                      |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                |  | 9a. FACILITY NAME (If not institution, give street and number)<br>1743 Grange Road                                                                                                                                                                                                              |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Dundalk                                                                                                                                         |  |
| 9c. COUNTY OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                |  | 10a. STATE<br>Maryland                                                                                                                                                                                                                                                                          |  | 10b. COUNTY<br>Baltimore                                                                                                                                                               |  |
| 10c. CITY, TOWN OR LOCATION<br>Dundalk                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                             |  | 10e. STREET AND NUMBER<br>1743 Grange Road                                                                                                                                             |  |
| 10f. ZIP CODE<br>21222                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                |  | 10g. CITIZEN OF WHAT COUNTRY?<br>United States                                                                                                                                                                                                                                                  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                                                                                             |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                                                                                                       |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 Years<br>College (1-4 or 5+) College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Automobile Repair                                                                                                                                                                 |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Self Employed                                                                                                                                        |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>John Kennedy White, Jr.                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Dorothy Margaret Winkler                                                                                                                                                                                                                   |  |                                                                                                                                                                                        |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Robert G. Gemmill                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1743 Grange Road Dundalk, Maryland 21222                                                                                                                                                       |  |                                                                                                                                                                                        |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                    |  |                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Holly Hill Mem. Pk. 11/11/94                                                                                                                                                                                 |  | 20c. LOCATION — City or Town, State<br>Middle River, MD                                                                                                                                |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br>Duda-Ruck Funeral Home of Dundalk, Inc.<br>7922 Wise Ave. Dundalk, MD 21222                                                                                                                                                                                 |  |                                                                                                                                                                                        |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Advanced CANCER R+ Breast 9 years<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. C BONE, LUNG<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. METASTASIS<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. — 2 years<br>Approximate Interval Between Onset and Death |  |                                                                                |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                        |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                 |  |                                                                                |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                        |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                        |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                     |  |                                                                                |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                          |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                        |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                    |  |                                                                                                                                                                                        |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                              |  |                                                                                |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                        |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Sompalli Prasada                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                |  | 29c. LICENSE NUMBER<br>D16/63                                                                                                                                                                                                                                                                   |  | 29d. DATE SIGNED (Month, Day, Year)                                                                                                                                                    |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>SOMPALLI SIVA RAMA K PRASAD                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                        |  |
| 31. DATE FILED (Month, Day, Year)<br>NOV 1 8 1994                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                                |  |                                                                                                                                                                                        |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33913

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                     |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Brenda Grenway                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                         |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>11 14 1994                                                                                                                                       |  | 3. TIME OF DEATH<br>M                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                     |
| 4. SOCIAL SECURITY NUMBER<br>216-54-1149                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                          |  | 8. AGE (In yrs. last birthday)<br>50 YRS.                                                                                                                                              |  | 7. DATE OF BIRTH (Month, Day, Year)<br>11-12-44                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                     |
| 9a. FACILITY NAME (If not institution, give street and number)<br>964 Franklinton Road                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                         |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE MD                                                                                                                                    |  | 9c. COUNTY OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                     |
| 10a. STATE<br>MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                         |  | 10b. COUNTY                                                                                                                                                                            |  | 10c. CITY, TOWN OR LOCATION<br>BALTIMORE MD                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                     |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                         |  | 10e. STREET AND NUMBER<br>964 FRANKLINTOWN RD                                                                                                                                          |  | 10f. ZIP CODE<br>21216                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                     |
| 10g. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                         |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR DATES                                                                                                                                                                                                                                                                                    |                                                                                                                                                     |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                         |  | 14. RACE - American Indian, Black, White, etc.<br>Specify: BLACK                                                                                                                       |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 10th College (1-4 or 5+) 10th                                                                                                                                                                                                                                                                                                     |                                                                                                                                                     |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Nursing Assistant                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                         |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Nursing Home                                                                                                                                         |  | 17. FATHER'S NAME (First, Middle, Last)<br>George J. Savage                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                     |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Olga Ballard                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                         |  | 19a. INFORMANT'S NAME (Type/print)<br>Kevin Grenway                                                                                                                                    |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>964 N. Franklinton Rd Balt, md 21223                                                                                                                                                                                                                                                                                            |                                                                                                                                                     |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                         |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>King Memorial Park 11/14                                                                            |  | 20c. LOCATION - City or Town, State<br>Randallstown, md                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                     |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Zubee Edmund                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                         |  | 22. NAME AND ADDRESS OF FACILITY<br>March F/H West<br>4300 Wabash Avenue                                                                                                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                     |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Carcinoma of Pancreas<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  | Approximate Interval Between Onset and Death<br>5 months                                                                                            |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Septicemia, Sepsis, Pyelonephritis                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                           |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                     |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                              |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                  |  | 28b. TIME OF INJURY<br>M                                                                                                                                                               |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                     |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 28e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                           |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                                                                                                                     |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Ronald S. Potorsky MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                         |  | 29c. LICENSE NUMBER<br>D13004                                                                                                                                                          |  | 29d. DATE SIGNED (Month, Day, Year)<br>11/15/94                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                     |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>RONALD S. POTORSKY M.D. 821 N. EUTAW ST #202 BALTIMORE MD 21201                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                     |
| 31. DATE FILED (Month, Day, Year)<br>NOV 18 1994                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                         |  | 32. REGISTRAR'S SIGNATURE<br>John A. Harkins                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                     |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





94 33914

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                 |  |                                                                                                                                                     |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>John Greene, SR.</b>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 2. DATE OF DEATH<br>MONTH <b>Nov</b> DAY <b>17</b> YEAR <b>94</b>                                                                                                                               |  | 3. TIME OF DEATH<br><b>8 30 A</b>                                                                                                                   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>251-48-7854</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 6. AGE (In yrs. last birthday)<br><b>60</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>May 5, 1934</b>                                                                                           |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>South Carolina</b>                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Upon Memorial Hospital</b>                                                                                                 |  | 9b. CITY, TOWN OR LOCATION OF DEATH                                                                                                                 |  |
| 9c. COUNTY OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 10a. STATE<br><b>Maryland</b>                                                                                                                                                                   |  |                                                                                                                                                     |  |
| 10b. COUNTY                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                                                                                                                                                 |  |                                                                                                                                                     |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 10e. STREET AND NUMBER<br><b>2205 Whittier Avenue</b>                                                                                                                                           |  |                                                                                                                                                     |  |
| 10f. ZIP CODE<br><b>21217</b>                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                     |  |                                                                                                                                                     |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                               |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>                                                                          |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>                                                                                                                                                                                                                                                                                                                        |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Electrical Maintenance</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Bethlehem Steel Corporation</b>                                                                                                                            |  |                                                                                                                                                     |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Frank Greene</b>                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Marie Byrd</b>                                                                                                                          |  |                                                                                                                                                     |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Delores Greene</b>                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2205 Whittier Avenue Baltimore, Maryland 21217</b>                                          |  |                                                                                                                                                     |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Garrison Maryland Veteran Cemetery 11/23</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 20c. LOCATION — City or Town, State<br><b>Owings Mills, Maryland</b>                                                                                                                            |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Kevin Parker</b>                                                                                    |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>Nutter Funeral Homes, Inc 2501 Gwynns Falls Parkway Baltimore, Maryland 21216</b>                                                                                                                                                                                                                                                                                                     |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. <b>Respiratory Arrest</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>Hypertension</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>metastatic squamous cell ca of the</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. <b>retrocolic Mesore</b><br><br>Approximate Interval Between Onset and Death<br><b>minutes</b><br><b>2 days</b><br><b>8 months</b> |  |                                                                                                                                                                                                 |  |                                                                                                                                                     |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                 |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                               |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                 |  | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                 |  |                                                                                                                                                     |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide                                                                                                                                                           |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                         |  |
| 28d. DESCRIBE HOW INJURY OCCURED                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                    |  |                                                                                                                                                     |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>[Signature] M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 29c. LICENSE NUMBER<br><b>044944</b>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/17/94</b>                                                                                              |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Edna Walker UMIA 201 E University Parkway</b>                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                 |  |                                                                                                                                                     |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                      |  | 32. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                 |  |                                                                                                                                                     |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94-6569-005

L.R.B.

Item# 9.b. G-film 717 per F.H 11/18/94 P.C

94 33915

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                   |                                           |                                                                                                                                                                                                 |  |                                                                                             |  |                                                                                                       |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>WOUBE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                   |                                           | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>NOV 13 1994                                                                                                                                               |  |                                                                                             |  | 3. TIME OF DEATH<br>2:55A M                                                                           |  |
| 4. SOCIAL SECURITY NUMBER<br>577-78-1221                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                                        | 6. AGE (In yrs. last birthday)<br>47 YRS. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>FEB 22 47                                                                                                                                             |  | 8. BIRTHPLACE (State or Foreign Country)<br>ETHIOPIA                                        |  |                                                                                                       |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>INNERLOOP I-695 @ SECURITY BLVD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                   |                                           | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Woodlawn                                                                                                                                                 |  |                                                                                             |  | 9c. COUNTY OF DEATH<br>BALTIMORE                                                                      |  |
| 10a. STATE<br>MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 10b. COUNTY<br>BALTO                                                                                                                                                                                                                                                                                              |                                           | 10c. CITY, TOWN OR LOCATION<br>BALTO                                                                                                                                                            |  |                                                                                             |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO       |  |
| 10e. STREET AND NUMBER<br>31 DOWLING CIRCLE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                   |                                           | 10f. ZIP CODE<br>21234                                                                                                                                                                          |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A                                                      |  |                                                                                                       |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                      |                                           | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: BLACK                            |  |                                                                                                       |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12TH<br>College (1-4 or 5+) 5TH                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)                                                                                                                                                                                                     |                                           |                                                                                                                                                                                                 |  | 16b. KIND OF BUSINESS/INDUSTRY                                                              |  |                                                                                                       |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>GEBRE GELETV                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                   |                                           | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>FANTAYE REJO                                                                                                                               |  |                                                                                             |  |                                                                                                       |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>AMSALE GELETU                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                   |                                           | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2215 CLOVILLE AVE BALTO MD 21214                                                               |  |                                                                                             |  |                                                                                                       |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                          |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, funeral home, etc.)<br>KING MEMORIAL PK 11/17/94                                                                                                                                                                                                            |                                           | 20c. LOCATION (City or Town, State)<br>RANDALLSTOWN. MD                                                                                                                                         |  |                                                                                             |  |                                                                                                       |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Willie Edmon</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                   |                                           | 22. NAME AND ADDRESS OF FACILITY<br>MARCH F/H-WEST 31                                                                                                                                           |  |                                                                                             |  |                                                                                                       |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. GUNSHOT WOUND OF HEAD, CONTACT<br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                                                                                                                                                   |                                           |                                                                                                                                                                                                 |  |                                                                                             |  | Approximate Interval Between Onset and Death                                                          |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                                   |                                           |                                                                                                                                                                                                 |  |                                                                                             |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                   |                                           |                                                                                                                                                                                                 |  |                                                                                             |  |                                                                                                       |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                   |                                           |                                                                                                                                                                                                 |  |                                                                                             |  |                                                                                                       |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) IN AUTO |                                           |                                                                                                                                                                                                 |  |                                                                                             |  |                                                                                                       |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input checked="" type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                      |  | 28a. DATE OF INJURY (Month, Day, Year)<br>11/13/94                                                                                                                                                                                                                                                                |                                           | 28b. TIME OF INJURY<br>0130AM                                                                                                                                                                   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 28d. DESCRIBE NOW INJURY OCCURRED<br>SHOT SELF                                                        |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br>695 EXIT 17, BALTIMORE, MD                                                                                                                                                                                                        |                                           |                                                                                                                                                                                                 |  |                                                                                             |  |                                                                                                       |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                   |                                           |                                                                                                                                                                                                 |  |                                                                                             |  |                                                                                                       |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Mario F. Gomb, Jr. MD</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                   |                                           | 29c. LICENSE NUMBER<br>O.C.M.E.                                                                                                                                                                 |  | 29d. DATE SIGNED (Month, Day, Year)<br>NOV 13, 1994                                         |  |                                                                                                       |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>MARIO F. GOMB, JR. MD 111 Penn Street, Baltimore, Maryland 21201                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                   |                                           |                                                                                                                                                                                                 |  |                                                                                             |  |                                                                                                       |  |
| 31. DATE FILED (Month, Day, Year)<br>NOV 18 1994                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 32. REGISTRAR'S SIGNATURE<br><i>G. J. Anderson</i>                                                                                                                                                                                                                                                                |                                           |                                                                                                                                                                                                 |  |                                                                                             |  |                                                                                                       |  |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



REG NO

DHMH-18 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**



94 33917

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                        |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Helen A. HARRIS</b>                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                |  | 2. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>15</b> YEAR <b>94</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 3. TIME OF DEATH<br><b>2:15 P M</b>                                                                                                                                                    |  |
| 4. SOCIAL SECURITY NUMBER<br><b>219-20-9529</b>                                                                                                                                                                                                                                                                                                                                                                                  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>85</b> YRS.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Nov 20, 1908</b>                                                                                                                             |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>THE KESWICK HOME</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>                                                                                                                                |  |
| 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                |  | 10a. STATE<br><b>Md</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 10b. COUNTY<br><b>BALTIMORE</b>                                                                                                                                                        |  |
| 10c. CITY, TOWN OR LOCATION<br><b>TOWSON</b>                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 10e. STREET AND NUMBER<br><b>513 WORCESTER Road</b>                                                                                                                                    |  |
| 10f. ZIP CODE<br><b>21204</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                              |  |                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                        |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Secretary</b>                                                                                                                                                                                                                                                                                                   |  |                                                                                |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>BALTIMORE County</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>ROBERT ANDERSON</b>                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MAGGIE LEE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                        |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>EUGENIA Rodgers</b>                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6830 Standish Dr. Hyattsville, Md 20784</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                        |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                  |  |                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Green Mount Cemetery</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                        |  |
| 20c. LOCATION — City or Town, State<br><b>BALTIMORE, Md.</b>                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Robert W. Jones</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                        |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>EVANS CHAPEL OF MEMORIES</b><br><b>8800 HARFORD Rd. Balto. Md. 21234</b>                                                                                                                                                                                                                                                                                                                  |  |                                                                                |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Parkinson's disease with dementia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br><br>d. |  |                                                                                                                                                                                        |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><br>                                                                                                                                                                                                                                                                                               |  |                                                                                |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                      |  |                                                                                |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                        |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                                                                                                                       |  |                                                                                |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                        |  |
| 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                        |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                             |  |                                                                                |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                        |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                           |  |                                                                                |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                        |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>M. Isabelle MacGregor MD</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                        |  |
| 29c. LICENSE NUMBER<br><b>D13657</b>                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>November 15, 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                        |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>M. ISABELLE MACGREGOR KESWICK 700 W 40th ST BALTO MD 21211</b>                                                                                                                                                                                                                                                                         |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                        |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                |  | 32. REGISTRAR'S SIGNATURE<br><i>John Anderson</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                        |  |

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION





94 33918

Item 2, g-717, 11-30-94, dr

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                          |  |                                                                                                                                                      |  |                                                                                                                                          |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MARYANN AGNES HARDCASTLE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                          |  | 2. DATE OF DEATH<br>MONTH <b>15</b> YEAR <b>1994</b><br><b>NOV. 16 1994 9:15P M</b>                                                                  |  | 3. TIME OF DEATH<br><b>9:15P M</b>                                                                                                       |  |
| 4. SOCIAL SECURITY NUMBER<br><b>197-36-4128</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 5. SEX<br><b>1 M 2 F</b> |  | 8. AGE (In yrs. last birthday)<br><b>47</b> YRS.                                                                                                     |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>May 2, 1947</b>                                                                             |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Saint Joseph Medical Center</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                          |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Towson, Maryland</b>                                                                                       |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>                                                                                                  |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                          |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                                                                                                      |  | 10d. INSIDE CITY LIMITS?<br><b>1 X YES 2 NO</b>                                                                                          |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 10b. COUNTY              |  | 10e. STREET AND NUMBER<br><b>Highwood Dr. 715</b>                                                                                                    |  | 10f. ZIP CODE<br><b>21212</b>                                                                                                            |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                          |  | 11. MARITAL STATUS<br><b>1 Never Married 2 Married 3 Widowed 4 X Divorced</b>                                                                        |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 YES 2 X NO</b><br>IF YES, GIVE WAR OR DATES                                             |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 YES 2 X NO</b> Specify:                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                          |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>white</b>                                                                           |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>12</b> Elementary/Secondary (9-12) <b>1</b> College (1-4 or 5+) |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Secretary</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                          |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>County of Philadelphia</b>                                                                                      |  |                                                                                                                                          |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Roland F. Kenny</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                          |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Agnes Penny</b>                                                                              |  |                                                                                                                                          |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Edward Kenny</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                          |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6713 Roosevelt Blvd. Philadelphia, PA. 19149</b> |  |                                                                                                                                          |  |
| 20a. METHOD OF DISPOSITION<br><b>1 X Burial 2 Cremation 3 Removal from State 4 Donation 8 Other (Specify)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                          |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>New Cathedral Cemetery 11/19/94 Philadelphia PA.</b>           |  |                                                                                                                                          |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Hilary L. Stallings Jr.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                          |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Stallings Funeral Home P.A. 3111 Mountain Road Pasadena MD 21122</b>                                          |  |                                                                                                                                          |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>metastatic colon carcinoma</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                          |  |                                                                                                                                                      |  |                                                                                                                                          |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>disseminated intravascular coagulation</b>                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                          |  |                                                                                                                                                      |  |                                                                                                                                          |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><b>1 YES 2 X NO</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                          |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1 YES 2 X NO</b>                                                   |  |                                                                                                                                          |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                          |  |                                                                                                                                                      |  |                                                                                                                                          |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1 YES 2 X NO</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                          |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> OTHER: <b>4 Nursing Home 5 Residence 8 Other (Specify)</b> |  |                                                                                                                                          |  |
| 27. MANNER OF DEATH<br><b>1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 8 Could not be determined</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                          |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                               |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                          |  |
| 28c. INJURY AT WORK?<br><b>1 YES 2 NO</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                          |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                    |  |                                                                                                                                          |  |
| 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                          |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                         |  |                                                                                                                                          |  |
| 29a. CERTIFIER (Check only one)<br><b>1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b><br><b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>                                                                                                                                                                                                                 |  |                          |  |                                                                                                                                                      |  |                                                                                                                                          |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>R. Hustig MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                          |  | 29c. LICENSE NUMBER<br><b>D36814</b>                                                                                                                 |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/18/94</b>                                                                                   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>R. Hustig MD 7505 Oak Dr. Suite 5-4 Towson MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                          |  |                                                                                                                                                      |  |                                                                                                                                          |  |
| 31. DATE OF DEATH<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                          |  |                                                                                                                                                      |  |                                                                                                                                          |  |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



94-6484-510

blh

94 33919

ITEMS: 23 PART I, 27, PER MEO FILM G-717 11/23/94 t.t

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                      |  |                                                                                                                                                    |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Walker Hudson, Jr.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov 09 1994</b>                                                                                                                             |  | 3. TIME OF DEATH<br><b>0350 M</b>                                                                                                                  |  |
| 4. SOCIAL SECURITY NUMBER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>40</b> YRS.                                                                                                                                     |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>12-2-1953</b>                                                                                            |  |
| 8a. FACILITY NAME (If not institution, give street and number)<br><b>130 Siegwart Lane</b>                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>                                                                                                                              |  | 8c. COUNTY OF DEATH<br><b>na</b>                                                                                                                   |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 10b. COUNTY<br><b>na</b>                                                                                                                                                                                                                                                                       |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                                                                                                                                      |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                               |  |
| 10e. STREET AND NUMBER<br><b>130 Siegwart Lane</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  | 10f. ZIP CODE<br><b>21229</b>                                                                                                                                                        |  | 10g. CITIZEN OF WHAT COUNTRY?                                                                                                                      |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                              |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                              |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                                                                            |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)                                                                           |  | 16b. KIND OF BUSINESS/INDUSTRY                                                                                                                     |  |
| 17. FATHER'S NAME (First, Middle, Last)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)                                                                                                                                    |  |                                                                                                                                                    |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>ocme</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)                                                                                        |  |                                                                                                                                                    |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>in state removal</b>                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)                                                                                                      |  | 20c. LOCATION — City or Town, State                                                                                                                |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Ronald Wade, Dir</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>State Anatomy Board<br/>655W. Baltimore St, Balto, MD 21201</b>                                                                               |  |                                                                                                                                                    |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>SEIZURE DISORDER</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>a.<br>b.<br>c.<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                      |  | Approximate Interval Between Onset and Death                                                                                                       |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                      |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                              |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                      |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                      |  |                                                                                                                                                    |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                    |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                      |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                              |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                               |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                       |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                      |  |                                                                                                                                                    |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>O.C.M.E.</b>                                                                                                                                               |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>Nov. 09 1994</b>                                                                                         |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>David R. Fowler 111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                      |  |                                                                                                                                                    |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                                                                                      |  |                                                                                                                                                    |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33920

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                      |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MARY E. HATHAWAY</b>                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                         |  | 2. DATE OF DEATH<br>MONTH <b>11</b> - DAY <b>16</b> - YEAR <b>94</b>                                                                                                                                |  | 3. TIME OF DEATH<br><b>1-05A M</b>                                                   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>240-32-5698</b>                                                                                                                                                                                                                                                                                                                                                                                  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                          |  | 6. AGE (In yrs. last birthday)<br><b>68</b> YRS.                                                                                                                                                    |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>June 10, 1926</b>                          |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>N.C.</b>                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                         |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Liberty Medical Center</b>                                                                                                     |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Balto</b>                                  |  |
| 9c. COUNTY OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                         |  | 10a. STATE<br><b>md</b>                                                                                                                                                                             |  |                                                                                      |  |
| 10b. COUNTY                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                         |  | 10c. CITY, TOWN OR LOCATION<br><b>Balto</b>                                                                                                                                                         |  |                                                                                      |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                         |  | 10e. STREET AND NUMBER<br><b>3658 Forest Hill Rd</b>                                                                                                                                                |  |                                                                                      |  |
| 10f. ZIP CODE<br><b>21207</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                         |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>                                                                                                                                                       |  |                                                                                      |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                           |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                     |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>              |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12+</b> College (1-4 or 5+)                                                                                                                                                                                                                                                                                                 |  | 16. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)                                                                                                                                                                                            |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Post office</b>                                                                                                                                                |  |                                                                                      |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Arthur Beasley</b>                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                         |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Katie Horton</b>                                                                                                                            |  |                                                                                      |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Charles Hathaway</b>                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                         |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3658 Forest Hill Rd Balto, md 21207</b>                                                         |  |                                                                                      |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place)<br><b>Arbuthus Memorial Park 12/24/94</b>                                                                                                                                                                            |  | 20c. LOCATION — City or Town, State<br><b>Arbuthus, md</b>                                                                                                                                          |  |                                                                                      |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Sala March</b>                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                         |  | 22. NAME AND ADDRESS OF FACILITY<br><b>March F. H. West 4300 Wabash Ave</b>                                                                                                                         |  |                                                                                      |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastasis Carcinoma of Stomach.</b>                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| a. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide                                                                                                                                        |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                  |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                     |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                           |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                     |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>R.M. SHAH M.D.</b>                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                         |  | 29c. LICENSE NUMBER<br><b>D19668</b>                                                                                                                                                                |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11-16-94</b>                               |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>R.M. SHAH, 2600 LIBERTY LANE AVE, Baltimore, MD.</b>                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                      |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                         |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                                                                                                     |  |                                                                                      |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33921

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                     |  |                                                                                                                                             |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>KATHLEEN WALLS HORELICK</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                        |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOV. 12 1994</b>                                                                                                                                           |  | 3. TIME OF DEATH<br><b>9:15 P M</b>                                                                                                         |  |
| 4. SOCIAL SECURITY NUMBER<br><b>052 32 8936</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                                         |  | 6. AGE (In yrs. last birthday)<br><b>56</b> YRS.                                                                                                                                                    |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>2-26-1938</b>                                                                                     |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Stella Maris Nurs Hm</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                        |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Towson</b>                                                                                                                                                |  | 9c. COUNTY OF DEATH<br><b>Baltimore Co</b>                                                                                                  |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                        |  | 10b. COUNTY<br><b>Baltimore Co</b>                                                                                                                                                                  |  | 10c. CITY, TOWN OR LOCATION<br><b>Towson</b>                                                                                                |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                     |  |                                                                                                                                             |  |
| 10e. STREET AND NUMBER<br><b>Stella Maris Nurs Hm<br/>Dulaney Valley Road</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                        |  | 10f. ZIP CODE<br><b>21204</b>                                                                                                                                                                       |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                 |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                       |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES <b>No</b>                                                                                                                                                          |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                     |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Retired: Teacher</b>                                                                                                                                                                               |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Education</b>                                                                                                                                                  |  |                                                                                                                                             |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William Louis Walls</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                        |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary Anna Kormanski</b>                                                                                                                     |  |                                                                                                                                             |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mr Brindell Horelick</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                        |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>59Glen Wood Avenue, Catonsville, MD 21228</b>                                                   |  |                                                                                                                                             |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                              |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>DATE                                                                                                                                                                                                                                |  | 20c. LOCATION — City or Town, State                                                                                                                                                                 |  |                                                                                                                                             |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Ronald Wade</i> <b>Ronald Wade, Dir</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                                        |  | 22. NAME AND ADDRESS OF FACILITY<br><b>State Anatomy Board<br/>655W. Baltimore St, Balto, MD 21201</b>                                                                                              |  |                                                                                                                                             |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. MULTIPLE MYELOMA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                     |  | Approximate Interval Between Onset and Death<br><b>2 yrs.</b>                                                                               |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                     |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                     |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) <b>Hospice</b> |  |                                                                                                                                                                                                     |  |                                                                                                                                             |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                          |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                                 |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                            |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                             |  |
| 28d. DESCRIBE NOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                        |  | 28e. PLACE OF INJURY — At home, farm, street, lecture, office building, etc. (Specify)                                                                                                              |  |                                                                                                                                             |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                     |  |                                                                                                                                             |  |
| 29. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                     |  |                                                                                                                                             |  |
| 29a. SIGNATURE AND TITLE OF CERTIFIER<br><i>K. Faulkner</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                        |  | 29c. LICENSE NUMBER<br><b>D 25643</b>                                                                                                                                                               |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/14/94</b>                                                                                      |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DR. KENDALL R. FAULKNER 2300 DULANEY VALLEY RD., TOWSON, MD 21204</b>                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                     |  |                                                                                                                                             |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                                        |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia H. Horelick</i>                                                                                                                                               |  |                                                                                                                                             |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.









94-6609-510

L.R.B.

ITEMS: 23 PART I, 27, 28a,b,d,e,f, PER MEO FILM 6-718 12/5/94 t.t

94 33923

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                      |  |                                                                                                           |  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>EDWARD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                         |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOV 14 1994</b>                                                                                                                                            |  |                                                                                      |  | 3. TIME OF DEATH<br><b>3:30P</b>                                                                          |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>213-58-2927</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                                                                                                                                                          |  | 6. AGE (In yrs. last birthday)<br><b>42</b> YRS.                                                                                                                                                    |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>01-19-52</b>                               |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>                                               |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>1329 W. NORTH AVE.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                         |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City.</b>                                                                                                                                       |  |                                                                                      |  | 9c. COUNTY OF DEATH                                                                                       |  |  |
| 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 10b. COUNTY                                                                                                                                                                                                                                                                                             |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>                                                                                                                                                     |  |                                                                                      |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO       |  |  |
| 10e. STREET AND NUMBER<br><b>1329 W. NORTH AVENUE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                         |  | 10f. ZIP CODE<br><b>21217</b>                                                                                                                                                                       |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                          |  |                                                                                                           |  |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                        |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>              |  |                                                                                                           |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>HOME IMPROVEMENT</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOME IMPROVEMENT</b>                                                                                                                                                                   |  |                                                                                                                                                                                                     |  | 16b. KIND OF BUSINESS/INDUSTRY                                                       |  |                                                                                                           |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>CHRISTOPHER JACKSON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                         |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>CATHERINE LOHNSON</b>                                                                                                                       |  |                                                                                      |  |                                                                                                           |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>ROONALD E.R. JOHNSON SR.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                         |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4400 MOREVIA RD. APT 2 BALTO. MD. 21206</b>                                                     |  |                                                                                      |  |                                                                                                           |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                      |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>METRO CREMATORY 11-16-94</b>                                                                                                                                                                                      |  | 20c. LOCATION — City or Town, State<br><b>CATONSVILLE MD.</b>                                                                                                                                       |  |                                                                                      |  |                                                                                                           |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                         |  | 22. NAME AND ADDRESS OF FACILITY<br><b>ALBERT P. WYLIE F/H PA<br/>638 N. GILMORE STREET 21217</b>                                                                                                   |  |                                                                                      |  |                                                                                                           |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>COCAINE AND NARCOTIC INTOXICATION</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br><br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                      |  | Approximate Interval Between Onset and Death                                                              |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                      |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                      |  |                                                                                                           |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                      |  |                                                                                                           |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                      |  |                                                                                                           |  |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input checked="" type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                               |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>FOUND 11-14-94</b>                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>3:00 P M</b>                                                                                                                                                              |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED<br><b>UNKNOWN</b>                                                       |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>FOUND AT HOME</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>1329 W. NORTH AVE. BALTIMORE, MARYLAND</b>                                                                                                                                                                              |  |                                                                                                                                                                                                     |  |                                                                                      |  |                                                                                                           |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                      |  |                                                                                                           |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                         |  | 29c. LICENSE NUMBER<br><b>O.C.M.E.</b>                                                                                                                                                              |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>NOV 15 1994</b>                            |  |                                                                                                           |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>David R. Fowler 111 Penn Street, Baltimore, Maryland 21201.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                      |  |                                                                                                           |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                     |  |                                                                                      |  |                                                                                                           |  |  |

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33924

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MIKHEL KODESH</b>                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH <b>NOVEMBER</b> DAY <b>13</b> YEAR <b>1994</b>                                                                                                                        |  | 3. TIME OF DEATH<br><b>3:45 P.M.</b>                                                            |  |
| 4. SOCIAL SECURITY NUMBER<br><b>224-21-1177</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>83</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Dec. 12, 1910</b>                                     |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Hebrew Home of Greater Wash.</b>                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Rockville</b>                                                                                                                                         |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>                                                        |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                |  | 10b. COUNTY<br><b>Montgomery</b>                                                                                                                                                                                                                                                               |  | 10c. CITY, TOWN OR LOCATION<br><b>Rockville</b>                                                                                                                                                 |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>6121 Montrose Road</b>                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  | 10f. ZIP CODE<br><b>20852</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>Latvia</b>                                                  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                               |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                      |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary (0-12)</b><br><b>12</b>                                                                                                                                                                                                                                                                                                                  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Sheet Metal Worker</b>                                                                                                                                                     |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Factory</b>                                                                                                                                                |  |                                                                                                 |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Shapsa Kodesh</b>                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ada Ekon</b>                                                                                                                            |  |                                                                                                 |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Sam Kodesh</b>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10804 Rippon Lodge Drive, Fairfax, Va. 22032</b>                                            |  |                                                                                                 |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>King David Mem. Gdn. 11-15 Falls Church, Va.</b>                                                                                                                                                         |  | 20c. LOCATION — City or Town, State                                                                                                                                                             |  |                                                                                                 |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Lisa D. Williams</b>                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Ives-Pearson Funeral Homes<br/>Falls Church, Va. 22046</b>                                                                                               |  |                                                                                                 |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →                                                                                                                                                                                                                                                                                                                                                            |  | a. <b>ACUTE RENAL FAILURE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>CONGESTIVE HEART FAILURE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. _____<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. _____                                                                                        |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>HEPATIC FAILURE</b>                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                        |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                   |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                          |  |                                                                                                 |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>P. Talwar, M.D.</b>                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>D 36552</b>                                                                                                                                                           |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/14/94</b>                                          |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>P-TALWAR, 6121 MONTROSE RD. ROCKVILLE MD. 20852</b>                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  | 32. REGISTRAR'S SIGNATURE<br><b>John Stuckey-Rodell</b>                                                                                                                                         |  |                                                                                                 |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1909.6 A. 12

94 33925

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |                                                  |                                                                                                                                                                                                     |                                                                                  |                                                                                                     |                                                                                                           |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>IRENE M. KIDD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |                                                  | 2. DATE OF DEATH<br>MONTH <b>NOV.</b> DAY <b>15</b> , YEAR <b>1994</b>                                                                                                                              |                                                                                  | 3. TIME OF DEATH<br><b>10:12 P M</b>                                                                |                                                                                                           |
| 4. SOCIAL SECURITY NUMBER<br><b>218-14-6483</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                             | 6. AGE (In yrs. last birthday)<br><b>76</b> YRS. | IF UNDER 1 YEAR<br>MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>                                                                                                                    | IF UNDER 24 HRS.<br>HOURS <input type="checkbox"/> MIN. <input type="checkbox"/> | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>MAR. 22, 1918</b>                                      |                                                                                                           |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>RIVERVIEW Nursing Home</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |                                                  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Balt, MD (ESSEX)</b>                                                                                                                                      |                                                                                  | 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>                                                             |                                                                                                           |
| 10a. STATE<br><b>MD.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 10b. COUNTY<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                            |                                                  | 10c. CITY, TOWN OR LOCATION<br><b>MIDDLE RIVER</b>                                                                                                                                                  |                                                                                  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |                                                                                                           |
| 10e. STREET AND NUMBER<br><b>1219 CHESAPEAKE AVE.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                            |                                                  | 10f. ZIP CODE<br><b>21220</b>                                                                                                                                                                       |                                                                                  | 10g. CITIZEN OF WHAT COUNTRY?                                                                       |                                                                                                           |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                           |                                                  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |                                                                                  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                             |                                                                                                           |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b></b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOMEMAKER</b>                                                                                                                                                                          |                                                  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>OWN HOME</b>                                                                                                                                                   |                                                                                  |                                                                                                     |                                                                                                           |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>GORDEN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |                                                  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>ESTHER JANE CLARKE</b>                                                                                                                      |                                                                                  |                                                                                                     |                                                                                                           |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>CHARLES W. KIDD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |                                                  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1219 CHESAPEAKE AVE. BALTIMORE, MD. 21220</b>                                                   |                                                                                  |                                                                                                     |                                                                                                           |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>GREEN MT. CREMATORY 11/17</b>                                                                                                                                                                                        |                                                  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MD.</b>                                                                                                                                        |                                                                                  |                                                                                                     |                                                                                                           |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Edison M. Perkins</i> <b>EDISON M. PERKINS</b><br><b>D 00083</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |                                                  | 22. NAME AND ADDRESS OF FACILITY<br><b>BRADLEY-ASHTON FUNERAL HOME INC.</b><br><b>2134 WILLOW SPRING RD. DUNDALK, MD</b>                                                                            |                                                                                  |                                                                                                     |                                                                                                           |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. <b>Coronary Artery Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>Cholesterol emboli syndrome</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>Renal insufficiency</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. <b>Congestive heart Failure</b><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                                            |                                                  |                                                                                                                                                                                                     |                                                                                  |                                                                                                     | Approximate Interval Between Onset and Death                                                              |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |                                                  |                                                                                                                                                                                                     |                                                                                  |                                                                                                     | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |                                                  |                                                                                                                                                                                                     |                                                                                  |                                                                                                     |                                                                                                           |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |                                                  |                                                                                                                                                                                                     |                                                                                  |                                                                                                     |                                                                                                           |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                  |                                                                                                                                                                                                     |                                                                                  |                                                                                                     |                                                                                                           |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>N/A</b>                                                                                                                                                                                                                                                       |                                                  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                     |                                                                                  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO     |                                                                                                           |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                     |                                                  | 28e. DESCRIBE HOW INJURY OCCURRED<br><b>N/A</b>                                                                                                                                                     |                                                                                  |                                                                                                     |                                                                                                           |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                            |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Bradford L. Elbright, M.D.</i>                                                                                                                                                                                                                                 |                                                  | 29c. LICENSE NUMBER<br><b>D45568</b>                                                                                                                                                                |                                                                                  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/16/94</b>                                              |                                                                                                           |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>9524 BELAIR RD BALT, MD 21236 PH 529-9311</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |                                                  |                                                                                                                                                                                                     |                                                                                  |                                                                                                     |                                                                                                           |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                                                                                                                                                                                                            |                                                  |                                                                                                                                                                                                     |                                                                                  |                                                                                                     |                                                                                                           |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





94 33926

Item#19b Per F.H. Film#717 11/18/94 R.M.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH / REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                  |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MARIE ARIETTA LANG</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>16</b> YEAR <b>94</b>                                                                                                                                |  | 3. TIME OF DEATH<br><b>6:05A M</b>                                                                               |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-01-8278</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>80</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>FEB. 4, 1914</b>                                                       |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>ST. AGNES HOSPITAL</b>                                                                                                     |  |                                                                                                                  |  |
| 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  | 9c. COUNTY OF DEATH                                                                                                                                                                             |  |                                                                                                                  |  |
| 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 10b. COUNTY<br><b>ANNE ARUNDEL</b>                                                                                                                                                                                                                                                             |  | 10c. CITY, TOWN OR LOCATION<br><b>LINTHICUM</b>                                                                                                                                                 |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                  |  |
| 10e. STREET AND NUMBER<br><b>701 JUNIPER ROAD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  | 10f. ZIP CODE<br><b>21090</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>                                       |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>12TH GRADE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOMEMAKER</b>                                                                                                                                                                 |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>OWN HOME</b>                                                                                                                                               |  |                                                                                                                  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>SAMUEL LANG</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>CARRIE SNOW RICHARDS</b>                                                                                                                |  |                                                                                                                  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>FREDERICK LANG</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>701 JUNIPER ROAD - LINTHICUM, MD 21090</b>                                                  |  |                                                                                                                  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>LOUON PARK CEMETERY</b>                                                                                                                                                                                  |  | 20c. LOCATION — City or Town, State<br><b>11/19 BALTIMORE</b>                                                                                                                                   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>HUBBARD FUNERAL HOME INC.<br/>4107 WILKENS AVENUE-BALTIMORE, MD 21229</b> |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>HUBBARD FUNERAL HOME INC.<br/>4107 WILKENS AVENUE-BALTIMORE, MD 21229</b>                                                                                |  |                                                                                                                  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><b>SEPTIC SHOCK</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><b>MYELODYSPLASTIC SYNDROME</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>DEHYDRATION</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Approximate Interval Between Onset and Death<br><b>24 hrs</b><br><b>14 mts</b><br><b>24 hrs</b> |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                                  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                      |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                               |  |                                                                                                                  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                    |  |                                                                                                                  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i> MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>D45530</b>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>Nov 16 1994</b>                                                        |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>S. SIVASAILAN 900 CATON AVE BALTIMORE - 21229.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                                                                                                 |  |                                                                                                                  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33927

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Thelma MCCLELLAND                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>November 15, 1994                                                                                                                                             |  | 3. TIME OF DEATH<br>7:55 P M                                                                        |                                                                                                |
| 4. SOCIAL SECURITY NUMBER<br>236-32-2767                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                             |  | 6. AGE (In yrs. last birthday)<br>68 YRS.                                                                                                                                                           |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Jan. 28, 1926                                             |                                                                                                |
| 8. BIRTHPLACE (State or Foreign Country)<br>West Virginia                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Franklin Square Hospital                                                                                                                                                                                                                 |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Rossville                                                                                                                                                    |  | 9c. COUNTY OF DEATH<br>Baltimore                                                                    |                                                                                                |
| 10a. STATE<br>Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 10b. COUNTY<br>Baltimore                                                                                                                                                                                                                                                                                   |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore                                                                                                                                                            |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |                                                                                                |
| 10e. STREET AND NUMBER<br>7306 Berkshire Road                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |  | 10f. ZIP CODE<br>21224                                                                                                                                                                              |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA                                                                |                                                                                                |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                           |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                                 |                                                                                                |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12th                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker                                                                                                                                                                                 |  | 16b. KIND OF BUSINESS/INDUSTRY                                                                                                                                                                      |  |                                                                                                     |                                                                                                |
| 17. FATHER'S NAME (First, Middle, Last)<br>William F. Reed                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Ruby McClure                                                                                                                                   |  |                                                                                                     |                                                                                                |
| 19a. INFORMANT'S NAME (Type/Print)<br>David McClelland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>942 Kinwat Ave. Baltimore Md. 21221                                                                |  |                                                                                                     |                                                                                                |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                               |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Holly Hill Cemetery 11/18/94                                                                                                                                                                                            |  | DATE<br>11/18/94                                                                                                                                                                                    |  | 20c. LOCATION — City or Town, State<br>Baltimore Md.                                                |                                                                                                |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>R. Terry Connelly                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br>Connelly Funeral Home of Essex<br>300 Mace Ave. Baltimore Md. 21221                                                                                             |  |                                                                                                     |                                                                                                |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. Progressive Respiratory Failure<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. End Stage COPD<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     | Approximate Interval Between Onset and Death                                                   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                     |  | 28a. DATE OF INJURY<br>(Month, Day, Year)                                                                                                                                                                                                                                                                  |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                            |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |                                                                                                |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                        |  |                                                                                                     |                                                                                                |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                              |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>J. B. Littleton MD                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br>109306                                                                                                                                                                       |  | 29d. DATE SIGNED (Month, Day, Year)<br>11-16-94                                                     |                                                                                                |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>J. B. Littleton MD 1012 North Pt. Rd. Balto., MD 21224                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                |
| 31. DATE FILED (Month, Day, Year)<br>11-16-94                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 32. REGISTRAR'S SIGNATURE<br>NOV 18 1994 John Andrew Barlett                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33928

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>WILLIAM G. MEND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                             |  | 2. DATE OF DEATH<br>MONTH <b>NOV.</b> DAY <b>04</b> YEAR <b>1994</b>                                                                                                                            |  | 3. TIME OF DEATH<br><b>2:00 P M</b>                                                             |                                                                                                       |
| 4. SOCIAL SECURITY NUMBER<br><b>216-34-0339</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                  |  | 6. AGE (In yrs. last birthday)<br><b>55</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)                                                             |                                                                                                       |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>505 W. OLD LIBERTY ROAD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>SYKESVILLE</b>                                                                                                                                        |  | 9c. COUNTY OF DEATH<br><b>CARROLL</b>                                                           |                                                                                                       |
| 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 10b. COUNTY<br><b>CARROLL CO.</b>                                                                                                                                                                                                                                                           |  | 10c. CITY, TOWN OR LOCATION<br><b>SYKESVILLE</b>                                                                                                                                                |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |                                                                                                       |
| 10e. STREET AND NUMBER<br><b>505 W. OLD LIBERTY RD.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                             |  | 10f. ZIP CODE<br><b>21784</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                  |                                                                                                       |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>AIR FORCE</b>                                                                                                                            |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.—<br>Specify:<br><b>WHITE</b>                     |                                                                                                       |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (13 or 5+) <b>4</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>ELECTRICAL ENGINEER</b>                                                                                                                                                 |  | 16b. KIND OF BUSINESS/INDUSTRY                                                                                                                                                                  |  |                                                                                                 |                                                                                                       |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>HOWARD LEROY MEND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                             |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>ELIZABETH B. (SCHMIDT) MEND</b>                                                                                                         |  |                                                                                                 |                                                                                                       |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>CAROL A. RUNION</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                             |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>820 S. CURLEY ST. BALTO. MD. 21224</b>                                                      |  |                                                                                                 |                                                                                                       |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                              |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>GARDENS OF FAITH CEM. 11-09</b>                                                                                                                                                                       |  | 20c. LOCATION — City or Town, State<br><b>ROSEDALE, MD.</b>                                                                                                                                     |  |                                                                                                 |                                                                                                       |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Thyph L. Jain</b> LIC.# <b>MD0677</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  | 22. NAME AND ADDRESS OF FACILITY<br><b>EVANS FUNERAL CHAPEL</b><br><b>5800 HARFORD RD.</b>                                                                                                      |  |                                                                                                 |                                                                                                       |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Cardiac Hypertrophy</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                 | Approximate Interval Between Onset and Death                                                          |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                 | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                      |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                      |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |                                                                                                       |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                             |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                          |  |                                                                                                 |                                                                                                       |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Theodore M. King</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  | 29c. LICENSE NUMBER<br><b>O.C.M.E.</b>                                                                                                                                                          |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>NOV. 05, 1994</b>                                     |                                                                                                       |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                             |  | 32. REGISTRAR'S SIGNATURE<br><b>John Andrew...</b>                                                                                                                                              |  |                                                                                                 |                                                                                                       |

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



94 33929

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                  |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                             |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>MARY M. MARINO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                  |  | 2. DATE OF DEATH<br>MONTH 11- DAY 14- YEAR 94                                                                                                                                                       |  | 3. TIME OF DEATH<br>6:15 a M                                                                        |                                                                                                                                             |
| 4. SOCIAL SECURITY NUMBER<br>220-24-0104                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                   |  | 6. AGE (In yrs. last birthday)<br>83 YRS.                                                                                                                                                           |  | 7. DATE OF BIRTH (Month, Day, Year)<br>OCT. 1, 1911                                                 |                                                                                                                                             |
| 9a. FACILITY NAME (If not institution, give street and number)<br>RIVERVIEW NURSING HOME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE                                                                                                                                                    |  | 9c. COUNTY OF DEATH<br>BALTIMORE                                                                    |                                                                                                                                             |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                  |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                             |
| 10a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 10b. COUNTY<br>BALTIMORE                                                                                                                         |  | 10c. CITY, TOWN OR LOCATION<br>WHITE MARSH                                                                                                                                                          |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |                                                                                                                                             |
| 10e. STREET AND NUMBER<br>11540 PHILADELPHIA ROAD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                  |  | 10f. ZIP CODE<br>21162                                                                                                                                                                              |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA                                                                |                                                                                                                                             |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>WHITE                                 |                                                                                                                                             |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>HOUSEWIFE                       |  | 16b. KIND OF BUSINESS/INDUSTRY<br>HOUSEKEEPING                                                                                                                                                      |  |                                                                                                     |                                                                                                                                             |
| 17. FATHER'S NAME (First, Middle, Last)<br>GIATIANO TORANDO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>THERESA UNKNOWN                                                                                                                                |  |                                                                                                     |                                                                                                                                             |
| 19a. INFORMANT'S NAME (Type/Print)<br>CHARLES M. MARINO, SR.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>11540 PHILADELPHIA RD. BALTIMORE, MD. 21162                                                        |  |                                                                                                     |                                                                                                                                             |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                     |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>GARDENS OF FAITH CEM. NOV. 17, 1994                           |  | 20c. LOCATION — City or Town, State<br>BALTIMORE, MARYLAND                                                                                                                                          |  |                                                                                                     |                                                                                                                                             |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Lassahn Funeral Home</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                  |  | 22. NAME AND ADDRESS OF FACILITY<br>LASSAHN FUNERAL HOME<br>7401 BELAIR ROAD BALTIMORE, MD 21236                                                                                                    |  |                                                                                                     |                                                                                                                                             |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Arteriosclerotic Coronary Vascular Disease</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                  |  |                                                                                                                                                                                                     |  |                                                                                                     | Approximate Interval Between Onset and Death<br><i>Unknown</i>                                                                              |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Polycystic Kidney Disease</i><br><i>History of Coronary Heart Failure</i>                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                  |  |                                                                                                                                                                                                     |  |                                                                                                     | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                  |  |                                                                                                                                                                                                     |  |                                                                                                     | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                           |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                           |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                            |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                              |  |                                                                                                     |                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                     |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                             |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                    |  |                                                                                                                                                  |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                             |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Michael Schwartz MD</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                  |  | 29c. LICENSE NUMBER<br>D19667                                                                                                                                                                       |  | 29d. DATE SIGNED (Month, Day, Year)<br>11/14/94                                                     |                                                                                                                                             |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>DR. MICHAEL SCHWARTZ BERDANN MEDICAL GROUP 606 HAMMONDS LANE 21225                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                  |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                             |
| 31. DATE FILED (Month, Day, Year)<br>NOV 18 1994                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Andrew Ruffolo</i>                                                                                                                                             |  |                                                                                                     |                                                                                                                                             |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1000-01-01

1000-01-01



94 33930

Item 1, g-717, 11-18-94, per F. H., dr

1 -  
FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                                                       |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><del>JAMES</del> <u>JAMES</u> <u>MAC DONALD</u> <u>SR.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                             |  | 2. DATE OF DEATH<br>MONTH <u>11</u> DAY <u>17</u> YEAR <u>94</u>                                                                                                                                |  | 3. TIME OF DEATH<br><u>510 A</u> M                                                          |                                                                                                       |
| 4. SOCIAL SECURITY NUMBER<br><u>192-18-5102</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                  |  | 6. AGE (In yrs. last birthday)<br><u>70</u> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><u>4/19/1924</u>                                     |                                                                                                       |
| 9a. FACILITY NAME (If not institution, give street and number)<br><u>Charlotte Hall Veteran Home</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                             |  | 9b. CITY, TOWN OR LOCATION OF DEATH                                                                                                                                                             |  | 9c. COUNTY OF DEATH<br><u>St. Mary's</u>                                                    |                                                                                                       |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                                                       |
| 10a. STATE<br><u>Md</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 10b. COUNTY<br><u>Baltimore</u>                                                                                                                                                                                                                                                             |  | 10c. CITY, TOWN OR LOCATION                                                                                                                                                                     |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO        |                                                                                                       |
| 10e. STREET AND NUMBER<br><u>3905 Forrester Avenue</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                             |  | 10f. ZIP CODE<br><u>21206</u>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                                                 |                                                                                                       |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><u>WW II</u>                                                                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><u>white</u>                  |                                                                                                       |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>8</u> College (1-4 or 5+) <u></u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                             |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><u>Foreman</u>                                                                    |  | 16b. KIND OF BUSINESS/INDUSTRY<br><u>Construction</u>                                       |                                                                                                       |
| 17. FATHER'S NAME (First, Middle, Last)<br><u>William MacDonald</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                             |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><u>Henrietta Spillman</u>                                                                                                                  |  |                                                                                             |                                                                                                       |
| 19a. INFORMANT'S NAME (Type/Print)<br><u>James MacDonald, Jr.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                             |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>528 Nottingham Road, Balto, Md. 21229</u>                                                   |  |                                                                                             |                                                                                                       |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><u>Holly Hill Memorial Gardens 11/21 Balto, Md.</u>                                                                                                                                                      |  | 20c. LOCATION — City or Town, State                                                                                                                                                             |  |                                                                                             |                                                                                                       |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><u>Phillip Harris</u> <u>MO0550</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                             |  | 22. NAME AND ADDRESS OF FACILITY<br><u>Sterling Ashton Funeral Home</u><br><u>736 Edmondson Avenue Balto, Md. 21228</u>                                                                         |  |                                                                                             |                                                                                                       |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>CONGESTIVE HEART FAILURE</u><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>e. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                             | Approximate interval Between Onset and Death<br><u>YEARS</u>                                          |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                             | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                                                       |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                                                       |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                                                       |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                            |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                      |  | 28b. TIME OF INJURY<br><u>M</u>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |                                                                                                       |
| 28d. DESCRIBE HOW INJURY OCCURED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                             |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                          |  |                                                                                             |                                                                                                       |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                                                       |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                                                       |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><u>[Signature]</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                             |  | 29c. LICENSE NUMBER<br><u>D29657</u>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><u>11/17/94</u>                                      |                                                                                                       |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                                                       |
| 31. DATE FILED (Month, Day, Year)<br><u>NOV 18 1994</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  | 32. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                                                                                                                                                 |  |                                                                                             |                                                                                                       |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or the attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33931

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |                                                                                                                                                    |                                                                                                                                                     |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ANTHONY F. MARKOWSKI SR.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH <b>NOV.</b> DAY <b>17</b> YEAR <b>1994</b>                                                                                                           |  | 3. TIME OF DEATH<br><b>7:45 A M</b>                                                                                                                |                                                                                                                                                     |
| 4. SOCIAL SECURITY NUMBER<br><b>216-01-2090</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     |  | 8. AGE (In yrs. last birthday)<br><b>81</b> YRS.                                                                                                                               |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>10-4-13</b>                                                                                              |                                                                                                                                                     |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>JOHNS HOPKINS BAY VIEW</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>                                                                                                                        |  | 9c. COUNTY OF DEATH                                                                                                                                |                                                                                                                                                     |
| 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  | 10b. COUNTY                                                                                                                                                                    |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>                                                                                                    |                                                                                                                                                     |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  | 10e. STREET AND NUMBER<br><b>3112 FAIT AVENUE</b>                                                                                                                              |  | 10f. ZIP CODE<br><b>21224</b>                                                                                                                      |                                                                                                                                                     |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES       |                                                                                                                                                     |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>                                                                                                     |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9 YEARS</b><br>College (14 or 5+) <b>College</b> |                                                                                                                                                     |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>METAL FINISHER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>GENERAL MOTORS</b>                                                                                                                        |  |                                                                                                                                                    |                                                                                                                                                     |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JOHN MARKOWSKI</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MARY KAPELA</b>                                                                                                        |  |                                                                                                                                                    |                                                                                                                                                     |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MRS JOAN M. MOORE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8031 MIDHAVEN RD. BALTO. MD. 21222</b>                                     |  |                                                                                                                                                    |                                                                                                                                                     |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>SACRED HEART OF JESUS 11-21 BALTO CO MD.</b>                                             |  | 20c. LOCATION — City or Town, State                                                                                                                |                                                                                                                                                     |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Charles R. Kaczorowski</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>KACZOROWSKI FUNERAL HOME<br/>2525 FLEET ST. BALTO., MD. 21224</b>                                                                       |  |                                                                                                                                                    |                                                                                                                                                     |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>RENAL FAILURE - UREMIA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><b>GASTROINTESTINAL BLEEDING</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>LIKELY METASTATIC CANCER (HISTORY OF PROSTATE AND COLON CANCER)</b><br>DUE TO (OR AS A CONSEQUENCE OF): |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |                                                                                                                                                    | Approximate Interval Between Onset and Death<br><b>1 WEEK</b><br><b>unknown</b><br><b>YEARS</b>                                                     |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DEHYDRATION/VOLUME DEPLETION</b><br><b>MAUNUTITION - DYSPHAGIA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |                                                                                                                                                    | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                               |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |                                                                                                                                                    | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                |  |                                                                                                                                                    |                                                                                                                                                     |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                        |                                                                                                                                                     |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                         |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                   |  |                                                                                                                                                    |                                                                                                                                                     |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |                                                                                                                                                    |                                                                                                                                                     |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Thomas H. Gasser, MD</i> SENIOR RESIDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>D 44923</b>                                                                                                                                          |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11-17-94</b>                                                                                             |                                                                                                                                                     |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>THOMAS GASSER, MD DEPT. OF MEDICINE, JOHNS HOPKINS BAYVIEW MED. CTR. 4940 EASTERN AVE BALTIMORE MD 21224</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |                                                                                                                                                    |                                                                                                                                                     |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  | 32. REGISTRAR'S SIGNATURE<br><i>John A. ...</i>                                                                                                                                |  |                                                                                                                                                    |                                                                                                                                                     |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33932

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                               |  |                                                                                                 |                                                                                                                                                    |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>BLANCHE HELEN MILLER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>12</b> YEAR <b>94</b>                                                                                                                              |  | 3. TIME OF DEATH<br><b>16:15 PM</b>                                                             |                                                                                                                                                    |
| 4. SOCIAL SECURITY NUMBER<br><b>217-30-1681</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>78</b> YRS.                                                                                                                                              |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>12-12-1915</b>                                        |                                                                                                                                                    |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>MEMORIAL HOSPITAL &amp; MED. CENTER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>CUMBERLAND, MD</b>                                                                                                                                  |  | 9c. COUNTY OF DEATH<br><b>ALLEGANY</b>                                                          |                                                                                                                                                    |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                               |  |                                                                                                 |                                                                                                                                                    |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 10b. COUNTY<br><b>Allegany County</b>                                                                                                                                                                                                                                                          |  | 10c. CITY, TOWN OR LOCATION<br><b>Cumberland</b>                                                                                                                                              |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |                                                                                                                                                    |
| 10e. STREET AND NUMBER<br><b>461 Goethe Street</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  | 10f. ZIP CODE<br><b>21502</b>                                                                                                                                                                 |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                     |                                                                                                                                                    |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>No</b>                                                                                                                                      |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |                                                                                                                                                    |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>Grammar</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 15b. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Waitress</b>                                                                                                                                                                  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Food</b>                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                    |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>James E. Lease</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Rosie May Bennett</b>                                                                                                                 |  |                                                                                                 |                                                                                                                                                    |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Kathleen Van Houten</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>461 Goethe Street, Cumberland, MD 21502</b>                                               |  |                                                                                                 |                                                                                                                                                    |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                            |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)                                                                                                                                                                                                                |  | DATE                                                                                                                                                                                          |  | 20c. LOCATION — City or Town, State                                                             |                                                                                                                                                    |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Ronald Wade, Dir</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY <b>State Anatomy Board</b><br><b>655W. Baltimore St, Balto, MD 21201</b>                                                                                     |  |                                                                                                 |                                                                                                                                                    |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Chronic Obstructive Lung Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                               |  |                                                                                                 | Approximate Interval Between Onset and Death                                                                                                       |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Cor Pulmonale</b><br><b>GI Bleeding</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                               |  |                                                                                                 | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                              |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                               |  |                                                                                                 | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                               |  |                                                                                                 |                                                                                                                                                    |
| 27. MANNER OF DEATH<br>1. <input checked="" type="checkbox"/> Natural 5. <input type="checkbox"/> Pending Investigation<br>2. <input type="checkbox"/> Accident 6. <input type="checkbox"/> Could not be determined<br>3. <input type="checkbox"/> Suicide 8. <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                  |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                               |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |                                                                                                                                                    |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                  |  |                                                                                                 |                                                                                                                                                    |
| 29a. CERTIFIER (Check only one)<br>1. <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                               |  |                                                                                                 |                                                                                                                                                    |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Dr. Robustiano Barrera</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>D 14865</b>                                                                                                                                                         |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11-13-94</b>                                          |                                                                                                                                                    |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DR. ROBUSTIANO BARRERA, MEMORIAL HOSPITAL MED. BLDG., CUMBERLAND, MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                               |  |                                                                                                 |                                                                                                                                                    |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  | 32. REGISTRAR'S SIGNATURE<br><b>John A. ...</b>                                                                                                                                               |  |                                                                                                 |                                                                                                                                                    |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33933

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                                        |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Lonnie James Nelson</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 11, 1994</b>                                                                                                                                      |  | 3. TIME OF DEATH<br>1:30 p M                                                                        |                                                                                                                                                        |
| 4. SOCIAL SECURITY NUMBER<br><b>213-07-1506</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                                                                                                                                                             |  | 8. AGE (In yrs. last birthday)<br><b>81 YRS.</b>                                                                                                                                                    |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Sept 16, 1913</b>                                      |                                                                                                                                                        |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>1043 N. Aisquith Street</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>                                                                                                                                             |  | 9c. COUNTY OF DEATH<br><b>Georgia</b>                                                               |                                                                                                                                                        |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                                        |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 10b. COUNTY                                                                                                                                                                                                                                                                                                |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                                                                                                                                                     |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |                                                                                                                                                        |
| 10e. STREET AND NUMBER<br><b>1043 N. Aisquith Street</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |  | 10f. ZIP CODE<br><b>21202</b>                                                                                                                                                                       |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                         |                                                                                                                                                        |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                           |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>                          |                                                                                                                                                        |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Steel Worker</b>                                                                                                                                                                       |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Koppers</b>                                                                                                                                                    |  |                                                                                                     |                                                                                                                                                        |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John Nelson</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Rosa Harrington</b>                                                                                                                         |  |                                                                                                     |                                                                                                                                                        |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Carolyn Lyles</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1826 E. Chase St. Baltimore, Maryland 21213</b>                                                 |  |                                                                                                     |                                                                                                                                                        |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                         |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Arbutus Memorial Park</b>                                                                                                                                                                                            |  | DATE<br><b>11/16</b>                                                                                                                                                                                |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Maryland</b>                                   |                                                                                                                                                        |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Kevin Parker</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Nutter Funeral Home Inc.<br/>2501 Gwynns Falls PKY. Baltimore, Md, 21216</b>                                                                                 |  |                                                                                                     |                                                                                                                                                        |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>MULTIPLE MYELOMA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST {<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     | Approximate Interval Between Onset and Death                                                                                                           |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                              |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                                        |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                               |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                     |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                     |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |                                                                                                                                                        |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  | 28d. DESCRIBE NOW INJURY OCCURRED                                                                                                                                                                   |  |                                                                                                     |                                                                                                                                                        |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                                        |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                                        |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Shirley H. [Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  | 29c. LICENSE NUMBER<br><b>D29071</b>                                                                                                                                                                |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11-16-94</b>                                              |                                                                                                                                                        |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>R. KRISHNAN, MD 84 N. EUTAW ST #305 BALTIMORE MD 21201</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                                     |                                                                                                                                                        |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                                                                                                     |  |                                                                                                     |                                                                                                                                                        |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





94 33934

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                         |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Carlos Jackson Pack</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov. 15, 1994</b>                                                                                                                                      |  | 3. TIME OF DEATH<br>M<br><b>M</b>                                                                                                       |  |
| 4. SOCIAL SECURITY NUMBER<br><b>234-56-0691</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     |  | 8. AGE (In yrs. last birthday)<br><b>62</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>July 31, 1932</b>                                                                          |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>603 Dorsey Ave.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Essex</b>                                                                                                                                             |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>West Virginia</b>                                                                        |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>                                                                                                                                                         |  |                                                                                                                                         |  |
| 10a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 10b. COUNTY<br><b>Baltimore</b>                                                                                                                                                                                                                                                                |  | 10c. CITY, TOWN OR LOCATION<br><b>Essex</b>                                                                                                                                                     |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                         |  |
| 10e. STREET AND NUMBER<br><b>603 Dorsey Ave.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  | 10f. ZIP CODE<br><b>21221</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                             |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                                                              |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10th</b><br>College (1-4 or 5+) <b>College</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Lift Truck Driver</b>                                                                                                                                                      |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Steel Co.</b>                                                                                                                                              |  |                                                                                                                                         |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Arthur Pack</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Priscilla Cadle</b>                                                                                                                     |  |                                                                                                                                         |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Rocky Pack</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>603 Dorsey Ave. Baltimore Md. 21221</b>                                                     |  |                                                                                                                                         |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Holly Hill Cemetery 11/18/94 Baltimore Md.</b>                                                                                                                                                           |  | 20c. LOCATION — City or Town, State                                                                                                                                                             |  |                                                                                                                                         |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>R. Terry Connelly</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Connelly Funeral Home of Essex<br/>300 Mace Ave. Baltimore Md. 21221</b>                                                                                 |  |                                                                                                                                         |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><b>Congestive Heart Failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Coronary atherosclerosis</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Diabetes</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Sequentially ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</b> |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  | Approximate Interval Between Onset and Death<br><b>2 months</b><br><b>years</b><br><b>years</b>                                         |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic obstructive pulmonary disease</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                                                         |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                           |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                        |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                         |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                               |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                            |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                         |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Paul Tecklenberg MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>D 14473</b>                                                                                                                                                           |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11-16-94</b>                                                                                  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Paul Tecklenberg MD 9105 Franklin Square Drive Baltimore MD 21237</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                         |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  | 32. REGISTRAR'S SIGNATURE<br><b>Jodi Davidson-Rodell</b>                                                                                                                                        |  |                                                                                                                                         |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33935

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                   |  |                                                                                                                                             |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>LORRAINE C. PRICE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                        |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>Nov. 14 1994                                                                                                                                                |  | 3. TIME OF DEATH<br>5 30 P. M.                                                                                                              |  |
| 4. SOCIAL SECURITY NUMBER<br>204-22-0092                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                         |  | 6. AGE (In yrs. last birthday)<br>66 YRS.                                                                                                                                                         |  | 7. DATE OF BIRTH (Month, Day, Year)<br>June 26, 1928                                                                                        |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>1315 Chesaco Ave. Apt. 217                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                        |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Rosedale                                                                                                                                                   |  | 9c. COUNTY OF DEATH<br>Baltimore                                                                                                            |  |
| 10a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                        |  | 10b. COUNTY<br>Baltimore                                                                                                                                                                          |  | 10c. CITY, TOWN OR LOCATION<br>Rosedale                                                                                                     |  |
| 10e. STREET AND NUMBER<br>1315 Chesaco Ave.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                        |  | 10f. ZIP CODE<br>21237                                                                                                                                                                            |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                        |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                       |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                                                            |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 11th grade<br>College (1-4 or 5+) College                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. DO NOT use retired.)                                                                                                                                                                             |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Manufacturing                                                                                                                                                   |  |                                                                                                                                             |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Thomas Emmett Price                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                        |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Myrtle Baker                                                                                                                                 |  |                                                                                                                                             |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mrs. Michelle Brogan                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                        |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5668 Leiden Rd. Baltimore, Md. 21206                                                             |  |                                                                                                                                             |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Parkwood Cemetery 11-18-94                                                                                                                                                                          |  | 20c. LOCATION — City or Town, State<br>Baltimore, Md.                                                                                                                                             |  |                                                                                                                                             |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Lassahn Funeral Home</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                        |  | 22. NAME AND ADDRESS OF FACILITY<br>Lassahn Funeral Home<br>7401 Belair Rd. Balto., Md. 21236                                                                                                     |  |                                                                                                                                             |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Bronchitis - Pneumonia</i><br>Approximate interval between Onset and Death <i>48 to 72 hrs</i><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><div style="display: flex; justify-content: space-between;"> <div> <i>on long standing COPD</i><br/> <i>with I.D.M. and</i><br/> <i>probable silent myocardial infarction</i> </div> <div> <i>&gt; 20 yrs</i><br/> <i>&gt; 20 yrs</i><br/> <i>5 yrs</i> </div> </div> |  |                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                   |  |                                                                                                                                             |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>HBP X &gt; 20 yrs.</i><br><i>Nicotine addiction Hx ETOH abuse &gt; 40 yrs.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                            |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                       |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                      |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                            |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                   |  |                                                                                                                                             |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Michael A. Hyle M.D.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                        |  | 29c. LICENSE NUMBER<br>D27693                                                                                                                                                                     |  | 29d. DATE SIGNED (Month, Day, Year)<br>11/15/94                                                                                             |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Michael A. Hyle, M. D. 6530 Walther Avenue Balto., Md. (319-9155)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                   |  |                                                                                                                                             |  |
| 31. DATE FILED (Month, Day, Year)<br>NOV 18 1994                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                        |  | 32. REGISTRAR'S SIGNATURE<br><i>Jill D. ...</i>                                                                                                                                                   |  |                                                                                                                                             |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33936

Item#4,9a,18,20c Per F.H. Film# G-717 11/18/94 R.M.

1 -  
FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Elsie Porter</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH <b>Nov</b> DAY <b>9</b> YEAR <b>1994</b>                                                                                                                              |  | 3. TIME OF DEATH<br>M                                                                           |                                                                                                       |
| 4. SOCIAL SECURITY NUMBER<br><b>216-12-4837</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>74</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>JAN 7 20 MD</b>                                       |                                                                                                       |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  | 9. COUNTY OF DEATH<br><b>MD</b>                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>1908 N. Fulton Avenue</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Balto</b>                                                                                                                                             |  |                                                                                                 |                                                                                                       |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| 10a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 10b. COUNTY                                                                                                                                                                                                                                                                                    |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTO</b>                                                                                                                                                     |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |                                                                                                       |
| 10e. STREET AND NUMBER<br><b>1098 N. FULTON AVE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  | 10f. ZIP CODE<br><b>21217</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>                                                   |                                                                                                       |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                         |                                                                                                       |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12TH</b><br>College (1-4 or 5+) <b>INSURANCE AGENT</b>                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>INSURANCE AGENT</b>                                                                                                                                                           |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>INSURANCE</b>                                                                                                                                              |  |                                                                                                 |                                                                                                       |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>RAY LEE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>PEARL HATH PEARL HOPWELL</b>                                                                                                            |  |                                                                                                 |                                                                                                       |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>DUBONNET PORTER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1908 N. FULTON AVE BALTO MD 21217</b>                                                       |  |                                                                                                 |                                                                                                       |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                             |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>NEW CATHEDRAL</b>                                                                                                                                                                                        |  | OATE<br><b>111494 BALTO MD</b>                                                                                                                                                                  |  | 20c. LOCATION — City or Town, State<br><b>BALTO MD</b>                                          |                                                                                                       |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Portia Elron</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>March F/H West<br/>4300 Wabash Avenue</b>                                                                                                                |  |                                                                                                 |                                                                                                       |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>BREAST CANCER</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 | Approximate Interval Between Onset and Death                                                          |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                         |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                        |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |                                                                                                       |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                               |  |                                                                                                 |                                                                                                       |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>R. Krishnan</i>                                                                                                                                                                                                                                    |  | 29c. LICENSE NUMBER<br><b>D29071</b>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11-15-94</b>                                          |                                                                                                       |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>R. KRISHNAN, MD 821 N. EUTAW ST #305 BALTIMORE MD 21201</b>                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 32. REGISTRAR'S SIGNATURE<br><i>John D. ...</i>                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33937

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                         |                                                             |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>William Parry</b>                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH <b>November</b> DAY <b>13</b> YEAR <b>1994</b>                                                                                                                        |  | 3. TIME OF DEATH<br><b>1:30 P M</b>                                                                                                     |                                                             |
| 4. SOCIAL SECURITY NUMBER<br><b>104-34-2276</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>65</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>7/20/29</b>                                                                                   |                                                             |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>St. Agnes Hospital</b>                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>                                                                                                                                         |  | 9c. COUNTY OF DEATH                                                                                                                     |                                                             |
| 10a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  | 10b. COUNTY<br><b>Baltimore</b>                                                                                                                                                                 |  | 10c. CITY, TOWN OR LOCATION<br><b>Arbutus</b>                                                                                           |                                                             |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  | 10e. STREET AND NUMBER<br><b>5216 Benson Avenue</b>                                                                                                                                             |  |                                                                                                                                         |                                                             |
| 10f. ZIP CODE<br><b>21227</b>                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                  |  |                                                                                                                                         |                                                             |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                               |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>white</b>                                                              |                                                             |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>College</b>                                                                                                                                                                                                                                                                               |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Maintenance</b>                                                                                                                                                               |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Community College</b>                                                                                                                                      |  |                                                                                                                                         |                                                             |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Frank Parry</b>                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Jean Walker</b>                                                                                                                         |  |                                                                                                                                         |                                                             |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Anna Marie Parry</b>                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6 K Kings Crossing Court, Cockeysville, MD 21030</b>                                        |  |                                                                                                                                         |                                                             |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metro Crematory, Inc. 11/18 Catonsville, Maryland</b>                                                                                                                                                    |  | 20c. LOCATION — City or Town, State                                                                                                                                                             |  |                                                                                                                                         |                                                             |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227</b>                                                                                |  |                                                                                                                                         |                                                             |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                         |                                                             |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →                                                                                                                                                                                                                                                                                                                                                            |  | a. <b>Intractable Cardiomyopathy</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>Diabetes Mellitus</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>Peripheral vascular disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. <b>Chronic Renal Failure</b>                                    |  |                                                                                                                                                                                                 |  |                                                                                                                                         | Approximate interval between Onset and Death<br><b>1 hr</b> |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                         |                                                             |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Coronary Artery Disease</b><br><b>HTN</b><br><b>CHF</b>                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                         |                                                             |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> ODA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                           |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |                                                             |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined                                                                                                                                                   |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                             |                                                             |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                            |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                         |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                    |  |                                                                                                                                         |                                                             |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                         |                                                             |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>S. Nagmi</b><br><b>SHAHID NAQVI MD.</b>                                                                                                                                                                                                                                                                                                                                          |  | 29c. LICENSE NUMBER<br><b>1436</b>                                                                                                                                                                                                                                                             |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/13/94</b>                                                                                                                                          |  |                                                                                                                                         |                                                             |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>SHAHID NAQVI 900 CATON AVE, ST. AGNES HOSP, BALTIMORE MD 21229.</b>                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                         |                                                             |
| 31. DATE SIGNED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                     |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                 |  |                                                                                                                                         |                                                             |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





94 33938

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                            |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                                                                                                                                                                                                                                                |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>EUGENE WILLIAM PARADISE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                            |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11-13-94</b>                                                                                                                                           |  | 3. TIME OF DEATH<br><b>6:50 A M</b>                                                         |                                                                                                                                                                                                                                                                                                |
| 4. SOCIAL SECURITY NUMBER<br><b>212143139</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                 |  | 6. AGE (In yrs. last birthday)<br><b>70</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>9-5-24</b>                                        |                                                                                                                                                                                                                                                                                                |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>DVA MEDICAL CENTER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                            |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>FORT HOWARD</b>                                                                                                                                       |  | 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>                                                     |                                                                                                                                                                                                                                                                                                |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                            |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                                                                                                                                                                                                                                                |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 10b. COUNTY<br><b>Baltimore County</b>                                                                                                                                     |  | 10c. CITY, TOWN OR LOCATION<br><b>Dundalk</b>                                                                                                                                                   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO        |                                                                                                                                                                                                                                                                                                |
| 10e. STREET AND NUMBER<br><b>512 Brandyvale Way</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                            |  | 10f. ZIP CODE<br><b>21222</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                 |                                                                                                                                                                                                                                                                                                |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>Yes 1950-51 1942-45</b> |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |                                                                                                                                                                                                                                                                                                |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b><br>College (1-4 or 5+) <b>College</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Electrician</b>                                        |  | 15b. KIND OF BUSINESS/INDUSTRY                                                                                                                                                                  |  |                                                                                             |                                                                                                                                                                                                                                                                                                |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John F. Paradise</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mae Northam</b>                                                                                                                         |  |                                                                                             |                                                                                                                                                                                                                                                                                                |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Louise Paradise</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>512 Brandyvale Way, Dundalk, MD 21222</b>                                                   |  |                                                                                             |                                                                                                                                                                                                                                                                                                |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                          |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)                                                                                            |  | DATE                                                                                                                                                                                            |  | 20c. LOCATION — City or Town, State                                                         |                                                                                                                                                                                                                                                                                                |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Ronald Wade, Dir</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br><b>State Anatomy Board<br/>655 W. Baltimore St, Balto, MD 21201</b>                                                                                         |  |                                                                                             |                                                                                                                                                                                                                                                                                                |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><b>s. END STAGE CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                            |  |                                                                                                                                                                                                 |  |                                                                                             | Approximate interval Between Onset and Death                                                                                                                                                                                                                                                   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>ADVANCED OSTEOPOROSIS</b><br><b>COMPRESSION FRACTURE OF T-7</b><br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                            |  |                                                                                                                                                                                                 |  |                                                                                             | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                          |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                            |  |                                                                                                                                                                                                 |  |                                                                                             | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                  |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                     |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |                                                                                                                                                                                                                                                                                                |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                            |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                               |  |                                                                                             |                                                                                                                                                                                                                                                                                                |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                   |  |                                                                                                                                                                            |  |                                                                                                                                                                                                 |  |                                                                                             | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>                                                                                                                                                                                                                                    |
| 29c. LICENSE NUMBER<br><b>D30528</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/13/94</b>                                                                                                                                          |  |                                                                                             |                                                                                                                                                                                                                                                                                                |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DR BALA DUGGIRALA, M.D.--9600 NORTH POINT ROAD--FORT HOWARD, MARYLAND 21052</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                            |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                                                                                                                                                                                                                                                |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                            |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                                                                                                 |  |                                                                                             |                                                                                                                                                                                                                                                                                                |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

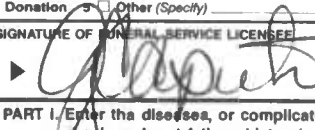

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-721 3/30/95 t.t

1 -  
FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                               |  |                                                                                                                                                                                |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>KIRSTIN ANN BLAIR ORR</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 2. DATE OF DEATH<br>MONTH <b>OCT.</b> DAY <b>16</b> YEAR <b>1994</b>                                                                                                                          |  | 3. TIME OF DEATH<br><b>10:00 AM</b>                                                                                                                                            |  |
| 4. SOCIAL SECURITY NUMBER<br><b>497 06 5949</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                                                                                                                                                   |  | 6. AGE (In yrs. last birthday)<br><b>2 YRS.</b>                                                                                                                                               |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>JULY 21, 1992</b>                                                                                                                    |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MISSOURI</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>1971 LAPOINTE DRIVE</b>                                                                                                  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>WHEATON</b>                                                                                                                          |  |
| 9c. COUNTY OF DEATH<br><b>MONTGOMERY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                 |  | 10b. COUNTY<br><b>MONTGOMERY</b>                                                                                                                                               |  |
| 10c. CITY, TOWN OR LOCATION<br><b>WHEATON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                               |  | 10e. STREET AND NUMBER<br><b>1971 LAPOINTE DRIVE</b>                                                                                                                           |  |
| 10f. ZIP CODE<br><b>20902</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>UNITED STATES</b>                                                                                                                                         |  | 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b>                                                                                                     |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>0</b> College (1-4 or 5+) <b>NONE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>NONE</b>                                                                     |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>N/A</b>                                                                                                                                   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>KELVIN B. ORR</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>GINGER S. PORTER</b>                                                                                                                  |  |                                                                                                                                                                                |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>GINGER S. ORR</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>SAME ADDRESS AS #10</b>                                                                   |  |                                                                                                                                                                                |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>HASTINGS MASON'S CEMETERY</b>                                                                           |  | 20c. LOCATION — City or Town, State<br><b>HASTINGS, FLA.</b>                                                                                                                   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 22. NAME AND ADDRESS OF FACILITY<br><b>IVES-PEARSON FUNERAL HOMES<br/>FALLS CHURCH, VA. 22046</b>                                                                                             |  |                                                                                                                                                                                |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>UNDETERMINED</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Approximate Interval Between Onset and Death |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                               |  |                                                                                                                                                                                |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                               |  |                                                                                                                                                                                |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                               |  |                                                                                                                                                                                               |  |                                                                                                                                                                                |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input checked="" type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                  |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>FOUND 10-16-94</b>                                                                                                                                                                                                                                                                                                                                                              |  | 28b. TIME OF INJURY<br><b>8:18 AM</b>                                                                                                                                                         |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                    |  |
| 28d. DESCRIBE HOW INJURY OCCURRED<br><b>UNKNOWN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>FOUND AT HOME</b>                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                               |  |                                                                                                                                                                                |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>1971 LAPOINTE DRIVE<br/>SILVER SPRING, MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                               |  |                                                                                                                                                                                |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Dennis J. Chute MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 29c. LICENSE NUMBER<br><b>O.C.M.E.</b>                                                                                                                                                        |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>OCT. 17, 1994</b>                                                                                                                    |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dennis Chute M.D. 111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                               |  |                                                                                                                                                                                |  |
| 31. DATE SIGNED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                               |  |                                                                                                                                                                                |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33940

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                            |  |                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                |                                                                                                       |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>LILLIAN VIGINIA REICHERT</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                            |  | 2. DATE OF DEATH<br>MONTH <b>Nov.</b> DAY <b>17<sup>th</sup></b> YEAR <b>94</b>                                                                                                                                                                                                                                          |  | 3. TIME OF DEATH<br><b>6:15 A M</b>                                                                                                                                            |                                                                                                       |
| 4. SOCIAL SECURITY NUMBER<br><b>213-20-2605</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>69</b> YRS.                                                                                                                                                                                                                                                                         |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>MARCH 26 1925</b>                                                                                                                    |                                                                                                       |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                            |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>STELLA MARIS Hospice</b>                                                                                                                                                                                                                            |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Towson</b>                                                                                                                           |                                                                                                       |
| 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                            |  | 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                            |  | 10b. COUNTY<br><b>BALTIMORE</b>                                                                                                                                                |                                                                                                       |
| 10c. CITY, TOWN OR LOCATION<br><b>PARKVILLE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                            |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                          |  | 10e. STREET AND NUMBER<br><b>2517 Linwood Road</b>                                                                                                                             |                                                                                                       |
| 10f. ZIP CODE<br><b>21234</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                            |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                                           |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |                                                                                                       |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                            |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                                                          |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>                                                                                                     |                                                                                                       |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                            |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>AT Home</b>                                                                                                                                                                                             |  | 16b. KIND OF BUSINESS/INDUSTRY                                                                                                                                                 |                                                                                                       |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William West</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Lillian Mac Knew</b>                                                                                                                                                                                                                                             |  |                                                                                                                                                                                |                                                                                                       |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Linda L. Myers</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>21300 Millers Mill Road, FreeLanO, Maryland 21053</b>                                                                                                                                                                |  |                                                                                                                                                                                |                                                                                                       |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                      |  |                                                                            |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>PARKWOOD CEMETERY 11-21-94</b>                                                                                                                                                                                                     |  | 20c. LOCATION — City or Town, State<br><b>Parkville, Maryland</b>                                                                                                              |                                                                                                       |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br><b>EVANS CHAPEL OF MEMORIES 8800 HARFORD ROAD - PARKVILLE</b>                                                                                                                                                                                                                        |  |                                                                                                                                                                                |                                                                                                       |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. HEPATIC FAILURE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                            |  |                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                | Approximate Interval Between Onset and Death<br><b>≥ 12 mos</b>                                       |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                            |  |                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                            |  |                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                |                                                                                                       |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                            |  |                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                |                                                                                                       |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>HOSPICE</b> |  |                                                                                                                                                                                |                                                                                                       |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                 |  |                                                                            |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                                   |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                |                                                                                                       |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                            |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                |                                                                                                       |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                            |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                             |  |                                                                                                                                                                                |                                                                                                       |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                               |  |                                                                            |  |                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                |                                                                                                       |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Kendall R Faulkner MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                            |  | 29c. LICENSE NUMBER<br><b>D25643</b>                                                                                                                                                                                                                                                                                     |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/17/94</b>                                                                                                                         |                                                                                                       |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DR. KENDALL FAULKNER 2300 DULANEY VALLEY ROAD TOWSON, MD 21204</b>                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                            |  |                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                |                                                                                                       |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                            |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                |                                                                                                       |

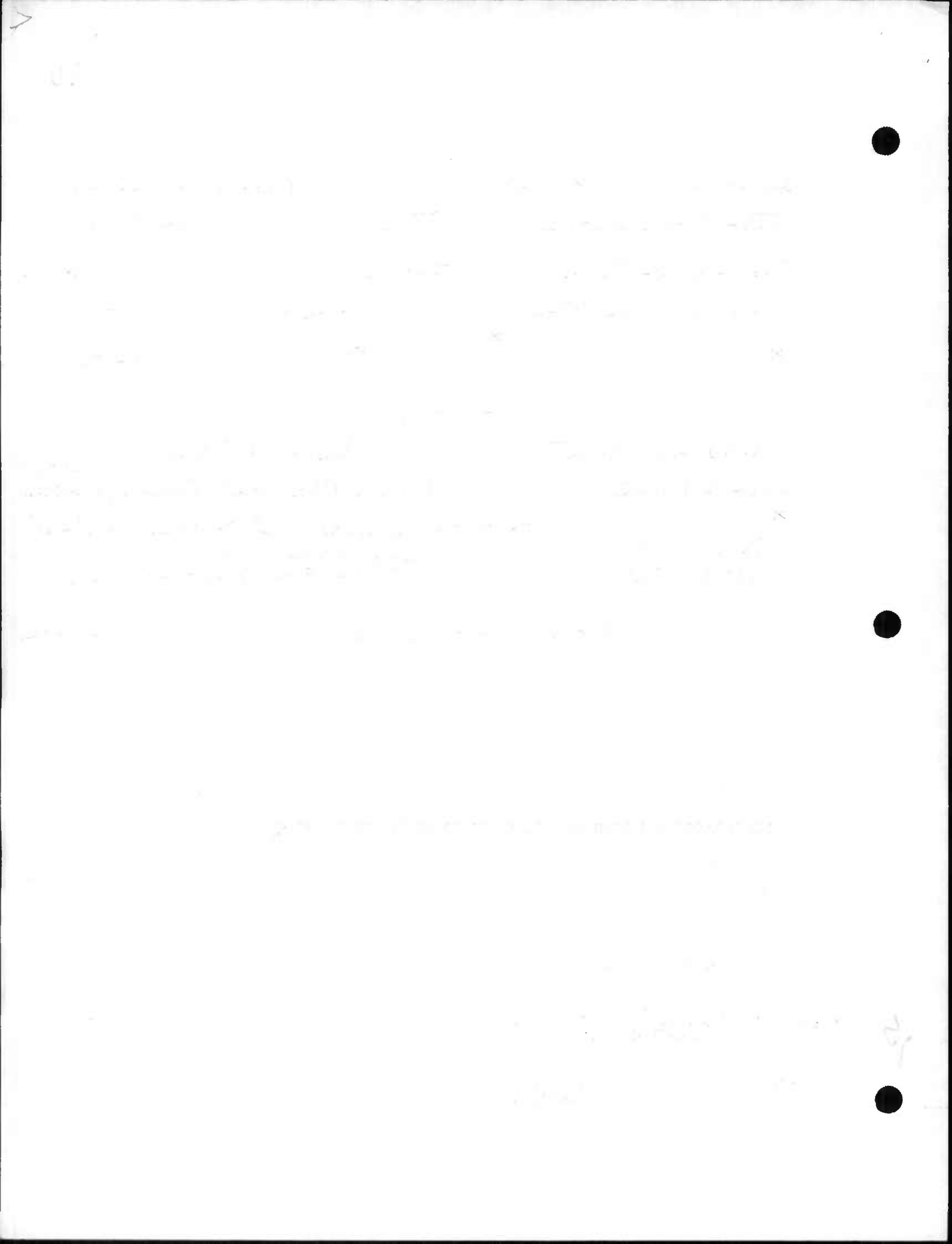
TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33941

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                  |                                                  |                                                                                                                                                                                                 |  |                                                                                                       |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>RUTH S. ROSE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                  |                                                  | 2. DATE OF DEATH<br>MONTH <b>NOV.</b> DAY <b>11</b> YEAR <b>1994</b>                                                                                                                            |  | 3. TIME OF DEATH<br><b>10 PM</b>                                                                      |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-22-9061</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                       | 6. AGE (In yrs. last birthday)<br><b>72</b> YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br><b>OCT. 10, 1922</b>                                                                                                                                     |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>ALTA PASS, N.C.</b>                                    |  |
| 9a. FACILITY NAME (If not Institution, give street and number)<br><b>538 COMPASS ROAD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                  |                                                  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>                                                                                                                                         |  | 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>                                                               |  |
| 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 10b. COUNTY<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                  |                                                  | 10c. CITY, TOWN OR LOCATION<br><b>21220</b>                                                                                                                                                     |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO       |  |
| 10e. STREET AND NUMBER<br><b>538 COMPASS ROAD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                  |                                                  | 10f. ZIP CODE<br><b>21220</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                           |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR OATES                                                                                                                                     |                                                  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>                            |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>ELECTRONICS TECHNICIAN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>ELECTRONICS</b>                                                                                                                                                 |                                                  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>ELECTRONICS</b>                                                                                                                                            |  |                                                                                                       |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>RICHARD L. SWOFFORD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                  |                                                  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>HATTIE FORTNER</b>                                                                                                                      |  |                                                                                                       |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>ROGER G. ROSE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                  |                                                  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>567 COMPASS ROAD BALTIMORE, MARYLAND 21220</b>                                              |  |                                                                                                       |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                            |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>GARDENS OF FAITH CEMETERY NOV. 14, 1994</b>                                                                                                                                                |                                                  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MARYLAND</b>                                                                                                                               |  |                                                                                                       |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Papermill Funeral Home</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                  |                                                  | 22. NAME AND ADDRESS OF FACILITY<br><b>LASSAHN FUNERAL HOME<br/>7401 BELAIR ROAD BALTIMORE, MARYLAND 21236</b>                                                                                  |  |                                                                                                       |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Multiple Myeloma</b><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                  |                                                  |                                                                                                                                                                                                 |  | Approximate Interval Between Onset and Death<br><b>1 wk</b>                                           |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                  |                                                  |                                                                                                                                                                                                 |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                  |                                                  |                                                                                                                                                                                                 |  |                                                                                                       |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                  |                                                  |                                                                                                                                                                                                 |  |                                                                                                       |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                  |                                                                                                                                                                                                 |  |                                                                                                       |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                       |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                           |                                                  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO           |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 28d. DESCRIBE NOW INJURY OCCURRED                                                                                                                                                                                                                                                |                                                  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                          |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                          |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                  |                                                  |                                                                                                                                                                                                 |  |                                                                                                       |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Mark L. ...</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                  |                                                  | 29c. LICENSE NUMBER<br><b>D-32453</b>                                                                                                                                                           |  | 29d. DATE SIGNED (Month, Day, Year)                                                                   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>3346 Papermill Rd. Phoenix, Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                  |                                                  |                                                                                                                                                                                                 |  |                                                                                                       |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                  |                                                  | 32. REGISTRAR'S SIGNATURE<br><i>John ...</i>                                                                                                                                                    |  |                                                                                                       |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





94 33942

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                               |                                                  |                                                                                                                                                                                                 |                                                  |                                                                                             |                                                                                                       |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|---------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>VERYL RUTHERFORD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                               |                                                  | 2. DATE OF DEATH<br>MONTH <b>NOV</b> DAY <b>14</b> YEAR <b>94</b>                                                                                                                               |                                                  | 3. TIME OF DEATH<br><b>945 P M</b>                                                          |                                                                                                       |
| 4. SOCIAL SECURITY NUMBER<br><b>168 24 4596</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                                    | 6. AGE (In yrs. last birthday)<br><b>66</b> YRS. | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>                                                                                                                                                | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b> | 7. DATE OF BIRTH (Month, Day, Year)<br><b>11-16-27</b>                                      |                                                                                                       |
| 9a. FACILITY NAME (If not Institution, give street and number)<br><b>Stella Maris Nurs Home</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                               |                                                  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Towson</b>                                                                                                                                            |                                                  | 9c. COUNTY OF DEATH<br><b>Baltimore Co</b>                                                  |                                                                                                       |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                               |                                                  |                                                                                                                                                                                                 |                                                  |                                                                                             |                                                                                                       |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 10b. COUNTY<br><b>Balto Co</b>                                                                                                                                                                                                                                                                                |                                                  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                                                                                                                                                 |                                                  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO        |                                                                                                       |
| 10a. STREET AND NUMBER<br><b>2902 W. Woodwell Road</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                               |                                                  | 10i. ZIP CODE<br><b>21222</b>                                                                                                                                                                   |                                                  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                 |                                                                                                       |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                        |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                               |                                                  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |                                                  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                  |                                                                                                       |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 10+</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Waitress</b>                                                                                                                                                                              |                                                  | 15b. KIND OF BUSINESS/INDUSTRY<br><b>Food</b>                                                                                                                                                   |                                                  |                                                                                             |                                                                                                       |
| 17. FATHER'S NAME (First, Middle, Last)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                               |                                                  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Bertha Ford</b>                                                                                                                         |                                                  |                                                                                             |                                                                                                       |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Evelyn Rooney</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                               |                                                  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2902 W. Woodwell Rd, Balto, MD 21222</b>                                                    |                                                  |                                                                                             |                                                                                                       |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                 |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)                                                                                                                                                                                                                               |                                                  | DATE                                                                                                                                                                                            |                                                  | 20c. LOCATION — City or Town, State                                                         |                                                                                                       |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Ronald Wade, Dir</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                               |                                                  | 22. NAME AND ADDRESS OF FACILITY<br><b>State Anatomy Board<br/>655W. Baltimore St, Balto, MD 21201</b>                                                                                          |                                                  |                                                                                             |                                                                                                       |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>RENAL CANCER</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                                                                                                                                               |                                                  |                                                                                                                                                                                                 |                                                  |                                                                                             | Approximate Interval Between Onset and Death<br><b>2 yrs.</b>                                         |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                               |                                                  |                                                                                                                                                                                                 |                                                  |                                                                                             | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                               |                                                  |                                                                                                                                                                                                 |                                                  |                                                                                             |                                                                                                       |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                               |                                                  |                                                                                                                                                                                                 |                                                  |                                                                                             |                                                                                                       |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>HOSPICE</b> |                                                  |                                                                                                                                                                                                 |                                                  |                                                                                             |                                                                                                       |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                         |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                        |                                                  | 28b. TIME OF INJURY<br>M <b>11</b>                                                                                                                                                              |                                                  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |                                                                                                       |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                               |                                                  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                          |                                                  |                                                                                             |                                                                                                       |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                               |                                                  | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                    |                                                  |                                                                                             |                                                                                                       |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                               |                                                  |                                                                                                                                                                                                 |                                                  |                                                                                             |                                                                                                       |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Kendall E Faulkner</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                               |                                                  | 29c. LICENSE NUMBER<br><b>D05643</b>                                                                                                                                                            |                                                  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/14/94</b>                                      |                                                                                                       |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DR. KENDALL FAULKNER 2300 DULANEY VALLEY ROAD TOWSON, MD 21204</b>                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                               |                                                  |                                                                                                                                                                                                 |                                                  |                                                                                             |                                                                                                       |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                               |                                                  | 32. REGISTRAR'S SIGNATURE<br><b>John B. ...</b>                                                                                                                                                 |                                                  |                                                                                             |                                                                                                       |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



blh

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                    |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Jerry Roberts</b>                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                           |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov. 09 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 3. TIME OF DEATH<br><b>0014</b> M                                                                                                                  |  |
| 4. SOCIAL SECURITY NUMBER                                                                                                                                                                                                                                                                                                                                                                                                    |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                                                |  | 6. AGE (In yrs. last birthday)<br><b>62</b> YRS.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>8-12-1932</b>                                                                                            |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>2800 St. Claire Drive</b>                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                           |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Marlow Heights</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 9c. COUNTY OF DEATH<br><b>Prince Georges</b>                                                                                                       |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                           |  | 10b. COUNTY<br><b>Prince George Co</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 10c. CITY, TOWN OR LOCATION<br><b>Oxen Hill</b>                                                                                                    |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                           |  | 10e. STREET AND NUMBER<br><b>5903 Fisher Road</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                    |  |
| 10f. ZIP CODE<br><b>20745</b>                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                           |  | 10g. CITIZEN OF WHAT COUNTRY?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                    |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                               |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                              |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                                                                                                                                                                                                        |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                            |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>9th</b>                                                                                                                                                                                                                                                                                                                                                |  | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>PRINTER</b>                                                                                                                                                                                              |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>PRINTING INDUSTRY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                    |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>UNKNOWN</b>                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                           |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>VIVIENE GOBELL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                    |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>WILLIAM B. ROBERTS</b>                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                           |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>148 CRANE COURT AIKEN, SOUTH CAROLINA 29803</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                    |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>in state removal METRO CREMATORY, INC.</b>                                                                                                                                                                                          |  | 20c. LOCATION — City or Town, State<br><b>11/28/94 BALTIMORE, MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Ronald Wade, Dir</b>                                                                               |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>State Anatomy Board 655W. Baltimore St, Balto, MD 21201</b>                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                           |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>e. Strangulation, Thermal and blunt force Injuries</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                    |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                           |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                    |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>at scene</b> |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                    |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined                                                                                                                                                |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>11-9-94</b>                                                                                                                                                                                                                                                                  |  | 28b. TIME OF INJURY<br><b>12-10<sup>PM</sup></b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                        |  |
| 28d. DESCRIBE HOW INJURY OCCURRED<br><b>subject strangled, beaten</b>                                                                                                                                                                                                                                                                                                                                                        |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>Roadway</b>                                                                                                                                                                                                                  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>2800 St. Claire Drive</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                    |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                    |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>[Signature]</b>                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                           |  | 29c. LICENSE NUMBER<br><b>O.C.M.E.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>Nov 09 1994</b>                                                                                          |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>David R Fowler 111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                    |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                                           |  | 32. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                    |  |

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Item#12.16.b. G-film 717 per F.M 11/25/94P.C  
ITEM: 18. PER INFORMANT FILM G-717 11/22/94 t.t  
Item 16a, g-717, 11-18-94, per F.H., dr

94 33944

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                      |                                  |                                                                                                           |  |                                                                                                                                             |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|----------------------------------|-----------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>ARTHUR LAWRENCE RUBEOR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>November 16, 1994                                                                                                                                                                                                                                                    |  | 3. TIME OF DEATH<br>M                                                                |                                  |                                                                                                           |  |                                                                                                                                             |  |
| 4. SOCIAL SECURITY NUMBER<br>002-16-8671                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                   |  | 6. AGE (In yrs. last birthday)<br>69 YRS.                                                                                                                                                                                                                                                                  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>June 12, 1925                              |                                  | 8. BIRTHPLACE (State or Foreign Country)<br>New Hampshire                                                 |  |                                                                                                                                             |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>8213 Rider Ave.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Towson                                                                                                                                                                                                                                                              |  |                                                                                      | 9c. COUNTY OF DEATH<br>Baltimore |                                                                                                           |  |                                                                                                                                             |  |
| 10a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                  |  | 10b. COUNTY<br>Baltimore                                                                                                                                                                                                                                                                                   |  | 10c. CITY, TOWN OR LOCATION<br>Towson                                                |                                  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO       |  |                                                                                                                                             |  |
| 10e. STREET AND NUMBER<br>8213 Rider Ave.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                  |  | 10f. ZIP CODE<br>21204                                                                                                                                                                                                                                                                                     |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                              |                                  |                                                                                                           |  |                                                                                                                                             |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                                                                                                        |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                  |                                  |                                                                                                           |  |                                                                                                                                             |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>4 yrs                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Counselor<br>Financial-Consular |  | 16b. KIND OF BUSINESS/INDUSTRY<br>— Signa Cigna                                                                                                                                                                                                                                                            |  |                                                                                      |                                  |                                                                                                           |  |                                                                                                                                             |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Arthur Rubeor                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Mary Elizabeth Larkin WALCH                                                                                                                                                                                                                           |  |                                                                                      |                                  |                                                                                                           |  |                                                                                                                                             |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Catherine E. Rubeor                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>8213 Rider Ave. Towson, Md. 21204                                                                                                                                                                         |  |                                                                                      |                                  |                                                                                                           |  |                                                                                                                                             |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Druid Ridge Cemetery 11-19                                    |  | 20c. LOCATION — City or Town, State<br>Pikesville, Md.                                                                                                                                                                                                                                                     |  |                                                                                      |                                  |                                                                                                           |  |                                                                                                                                             |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                  |  | 22. NAME AND ADDRESS OF FACILITY<br>Ruck Towson Funeral Home, Inc.<br>1050 York Rd. Towson, Md. 21204                                                                                                                                                                                                      |  |                                                                                      |                                  |                                                                                                           |  |                                                                                                                                             |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Pancreatic Cancer</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b.<br>c.<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                      |                                  | Approximate Interval Between Onset and Death<br>5 mos                                                     |  |                                                                                                                                             |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                      |                                  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 28a. DATE OF INJURY<br>(Month, Day, Year)                                                                                                        |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                                                                                                                                   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |                                  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                         |  |                                                                                                                                             |  |
| 29a. CERTIFIER<br>(Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                                                                                                                                                                                                                                                                  |  |                                                                                      |                                  | 29c. LICENSE NUMBER<br>D30529                                                                             |  | 29d. DATE SIGNED (Month, Day, Year)<br>11/16/94                                                                                             |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Dr. Paul Celano Greater Baltimore Medical Center Towson, Md. 21204                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                      |                                  |                                                                                                           |  |                                                                                                                                             |  |
| 31. DATE FILED (Month, Day, Year)<br>NOV 18 1994                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                  |  | 32. REGISTERED SIGNATURE<br>                                                                                                                                                                                                                                                                               |  |                                                                                      |                                  |                                                                                                           |  |                                                                                                                                             |  |



94 33945

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                            |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------|--|
| 1. DECEASED'S NAME (First, Middle, Last)<br><b>VERTILLAS REED</b>                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                              |  | 2. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>16</b> YEAR <b>94</b>                                                                                                                                                                                                                               |  | 3. TIME OF DEATH<br><b>8:35 A M</b>                                        |  |
| 4. SOCIAL SECURITY NUMBER<br><b>247-44-2295</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                   |  | 6. AGE (In yrs. last birthday)<br><b>64</b> YRS.                                                                                                                                                                                                                                               |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>7-27-30</b>                      |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>MARYLAND Gen. Hosp.</b>                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                              |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTO.</b>                                                                                                                                                                                                                                           |  | 9c. COUNTY OF DEATH                                                        |  |
| 10a. STATE<br><b>md.</b>                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                              |  | 10b. COUNTY                                                                                                                                                                                                                                                                                    |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTO.</b>                               |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                              |  | 10e. STREET AND NUMBER<br><b>2013 CLIFTWOOD AVE</b>                                                                                                                                                                                                                                            |  | 10f. ZIP CODE<br><b>21213</b>                                              |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                               |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                                |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b> |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input checked="" type="checkbox"/> College (14 or 5+)                                                                                                                                                                                                                                                                        |  |                                                                                                                                              |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife</b>                                                                                                                                                                 |  | 16b. KIND OF BUSINESS/INDUSTRY                                             |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Unknown King</b>                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                              |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Annie Mac Holbway</b>                                                                                                                                                                                                                  |  |                                                                            |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Oliver Reed</b>                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                              |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2013 CLIFTWOOD AVE BALTO. MD 21213</b>                                                                                                                                                     |  |                                                                            |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |  |                                                                                                                                              |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place)<br><b>Vashell Cem 10/94</b>                                                                                                                                                                                  |  | 20c. LOCATION — City or Town, State<br><b>BALTO. MD</b>                    |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Justin Byrne</b>                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                              |  | 22. NAME AND ADDRESS OF FACILITY<br><b>BETH'S FUNERAL HOME<br/>1124 N. CAROLINE ST. BALTO. MD 21213</b>                                                                                                                                                                                        |  |                                                                            |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                    |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                            |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                            |  |
| a. <b>Arrhythmia</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Immediate</b>                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                            |  |
| b. <b>ELECTROLYTE IMBALANCE</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Immediate</b>                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                            |  |
| c. <b>CHRONIC RENAL FAILURE</b> DUE TO (OR AS A CONSEQUENCE OF): <b>5 years</b>                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                            |  |
| d.                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                            |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                            |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                            |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                           |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                            |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                              |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                            |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined                                                                                                                                                   |  |                                                                                                                                              |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                            |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                              |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                              |  |                                                                            |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                              |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                   |  |                                                                            |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                            |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Justin P. Byrne MD</b>                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                              |  | 29c. LICENSE NUMBER<br><b>89203</b>                                                                                                                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/16/94</b>                     |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Justin Byrne, M.D. c.o Maryland General Hospital</b>                                                                                                                                                                                                                                                                               |  |                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                            |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                              |  | 32. REGISTRAR'S SIGNATURE<br><b>John D. ...</b>                                                                                                                                                                                                                                                |  |                                                                            |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FIELD

NO. 2

ADDITIONAL

FOR THE FINANCE

SECTION

100-100000-100

4



94 33946

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Sara Angela Reed                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                 |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>11 17 94                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 3. TIME OF DEATH<br>5:30 A M                                                                                                                                                                                                                                                                                                                                                                                                     |  |
| 4. SOCIAL SECURITY NUMBER<br>224-80-9349                                                                                                                                                                                                                                                  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                  |  | 6. AGE (In yrs. last birthday)<br>43 YRS.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>12 07 50                                                                                                                                                                                                                                                                                                                                                                               |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>N.C.                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                 |  | 9a. FACILITY NAME (If not institution, give street and number)<br>2053 E. 31st St.                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                 |  |
| 9c. COUNTY OF DEATH                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                 |  | 10a. STATE<br>Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 10b. COUNTY                                                                                                                                                                                                                                                                                                                                                                                                                      |  |
| 10c. CITY, TOWN OR LOCATION<br>Baltimore                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                 |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 10e. STREET AND NUMBER<br>3711 Liberty Heights Ave.                                                                                                                                                                                                                                                                                                                                                                              |  |
| 10f. ZIP CODE<br>21215                                                                                                                                                                                                                                                                    |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.                                                                                                                                                                                                           |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                                 |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                                                                                       |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: Black                                                                                                                                                                                |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Besutician                                                                                                                                                                                                                                                                                                      |  |
| 16b. KIND OF BUSINESS/INDUSTRY                                                                                                                                                                                                                                                            |  | 17. FATHER'S NAME (First, Middle, Last)                                                                                                                                                                                                         |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Ethel Crew                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 19a. INFORMANT'S NAME (Type/Print)<br>Doris Williams                                                                                                                                                                                                                                                                                                                                                                             |  |
| 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5275 Reisterstown Rd. Balto. Md. 21215                                                                                                                                                   |  | 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Western Star Cemetery 11/18/94                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 20c. LOCATION — City or Town, State<br>Balto. Md.                                                                                                                                                                                                                                                                                                                                                                                |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Robert M. Wainwright                                                                                                                                                                                                                         |  | 22. NAME AND ADDRESS OF FACILITY<br>Wainwright Funeral Home<br>2700 Edmondson Ave. Balto. Md. 21223                                                                                                                                             |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>Renal Failure<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>a. AIDS NEPHROPATHY<br>b. ACQUIRED IMMUNODEFICIENCY SYNDROME<br>c.<br>d. |  | Approximate Interval Between Onset and Death<br>5 Wks.<br>8 mos.<br>5 Yrs.                                                                                                                                                                                                                                                                                                                                                       |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Cytomegalovirus Infection                                                                                                                                       |  |                                                                                                                                                                                                                                                 |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                           |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                       |  |                                                                                                                                                                                                                                                 |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify)                                                                                                                       |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                          |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                             |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                         |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                          |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Robert Kent MD                                                                                                                                                                                                                                   |  | 29c. LICENSE NUMBER<br>D06966                                                                                                                                                                                                                   |  | 29d. DATE SIGNED (Month, Day, Year)<br>11/17/94                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Robert Kent MD 1001 Cathedral St. Baltimore, Md. 21201                                                                                                                                                                                                                                                                                    |  |
| 31. DATE FILED (Month, Day, Year)<br>NOV 18 1994                                                                                                                                                                                                                                          |  | 32. REGISTRAR'S SIGNATURE<br>A. M. R. R. R.                                                                                                                                                                                                     |  | 33. TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 34. TO BE COMPLETED BY FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                                          |  |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33947

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                      |  |                                                                                                     |  |                                                         |  |                                                 |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------|--|---------------------------------------------------------|--|-------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>ADELINA R STARR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>November 11 1994                                                                                                                                                                                                                                                     |  |                                                                                                                                      |  | 3. TIME OF DEATH<br>8:30 AM M                                                                       |  |                                                         |  |                                                 |  |
| 4. SOCIAL SECURITY NUMBER<br>213-10-9007                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                   |  | 6. AGE (In yrs. last birthday)<br>90 YRS.                                                                                                                                                                                                                                                                  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                                                                                       |  | IF UNDER 24 HRS.<br>HOURS MIN.                                                                      |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Nov. 21, 1903 |  | 8. BIRTHPLACE (State or Foreign Country)<br>Md. |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>KESWICK Nursing Center                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City                                                                                |  |                                                                                                     |  | 9c. COUNTY OF DEATH                                     |  |                                                 |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                      |  |                                                                                                     |  |                                                         |  |                                                 |  |
| 10a. STATE<br>Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 10b. COUNTY                                                                                                                                      |  | 10c. CITY, TOWN OR LOCATION<br>Hamilton                                                                                                                                                                                                                                                                    |  |                                                                                                                                      |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |                                                         |  |                                                 |  |
| 10e. STREET AND NUMBER<br>6413 FAIR OAKS Ave                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  | 10f. ZIP CODE<br>21214                                                                                                               |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA                                                                |  |                                                         |  |                                                 |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                                                                                                        |  |                                                                                                                                      |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                                 |  |                                                         |  |                                                 |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>OFFICE MANAGER                                                                                                                                                                            |  |                                                                                                                                      |  | 16b. KIND OF BUSINESS/INDUSTRY<br>INSURANCE                                                         |  |                                                         |  |                                                 |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>JOSEPH SURESCH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>WILLIE HAYDEN                                                                   |  |                                                                                                     |  |                                                         |  |                                                 |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>RUTH FRANKLIN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6605 LAURELTON Ave Balto. Md. 21214 |  |                                                                                                     |  |                                                         |  |                                                 |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>PARKWOOD Cemetery 11/14/94                                                                                                                                                                                              |  |                                                                                                                                      |  | 20c. LOCATION — City or Town, State<br>PARKVILLE Md                                                 |  |                                                         |  |                                                 |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Robert W. Givens                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br>EVANS Chapel of MEMORIES<br>8800 HARFORD Rd. Balto. Md. 21234                                    |  |                                                                                                     |  |                                                         |  |                                                 |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. RENAL FAILURE<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. ASCVD<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. CHRONIC GI BLEEDING<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. ULCERATIVE COLITIS<br>Approximate Interval Between Onset and Death<br>1 YEAR<br>YEARS<br>3 MONTHS<br>20 YEARS |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                      |  |                                                                                                     |  |                                                         |  |                                                 |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>OSTEOPOROSIS<br>Dementia                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                      |  |                                                                                                     |  |                                                         |  |                                                 |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                      |  |                                                                                                     |  |                                                         |  |                                                 |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                      |  |                                                                                                     |  |                                                         |  |                                                 |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                      |  |                                                                                                     |  |                                                         |  |                                                 |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                      |  |                                                                                                     |  |                                                         |  |                                                 |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                             |  |                                                                                                                                                  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)                                                                                                                                                                                                                                                                  |  | 28b. TIME OF INJURY<br>M                                                                                                             |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  | 28d. DESCRIBE HOW INJURY OCCURRED                       |  |                                                 |  |
| 28a. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                  |  | 28i. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                               |  |                                                                                                                                      |  |                                                                                                     |  |                                                         |  |                                                 |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                      |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                      |  |                                                                                                     |  |                                                         |  |                                                 |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>[Signature]                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  | 29c. LICENSE NUMBER<br>12379                                                                                                         |  | 29d. DATE SIGNED (Month, Day, Year)<br>November 11, 1994                                            |  |                                                         |  |                                                 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Charles Adenyan Jr. 700 W. 40th St. Baltimore, MD 21201                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                      |  |                                                                                                     |  |                                                         |  |                                                 |  |
| 31. DATE FILED (Month, Day, Year)<br>NOV 18 1994                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                  |  | 32. REGISTRAR'S SIGNATURE<br>[Signature]                                                                                                                                                                                                                                                                   |  |                                                                                                                                      |  |                                                                                                     |  |                                                         |  |                                                 |  |



94 33948

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>John BERKLEY Stricker</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>17</b> YEAR <b>94</b>                                                                                                                                |  | 3. TIME OF DEATH<br><b>7:30 AM</b>                                                              |                                                                                                       |
| 4. SOCIAL SECURITY NUMBER<br><b>216-10-7446 A</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     |  | 8. AGE (In yrs. last birthday)<br><b>84</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Oct. 10, 1910</b>                                     |                                                                                                       |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>St. Agnes Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>                                                                                                                                         |  | 9c. COUNTY OF DEATH<br><b>Maryland</b>                                                          |                                                                                                       |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 10b. COUNTY<br><b>Baltimore</b>                                                                                                                                                                                                                                                                |  | 10c. CITY, TOWN OR LOCATION<br><b>Catonsville</b>                                                                                                                                               |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |                                                                                                       |
| 10e. STREET AND NUMBER<br><b>227 Westowne Road</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  | 10f. ZIP CODE<br><b>21229</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                  |                                                                                                       |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |                                                                                                       |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b></b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  | 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Shipping Foreman</b>                                                           |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Paper Board Company</b>                                    |                                                                                                       |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Charles Henry Stricker</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Maggie Virginia Seamount</b>                                                                                                            |  |                                                                                                 |                                                                                                       |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>John J. Stricker Sr. (Son)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>404 Westshire Drive Catonsville Maryland 21228</b>                                          |  |                                                                                                 |                                                                                                       |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>New Cathedral Cemetery 11/19/94</b>                                                                                                                                                                      |  | 20c. LOCATION — City or Town, State<br><b>Baltimore Maryland</b>                                                                                                                                |  |                                                                                                 |                                                                                                       |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>R. Co. Witzke</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Leroy M &amp; Russell C Witzke Funeral Homes<br/>1630 Edmondson Avenue Catonsville Maryland</b>                                                          |  |                                                                                                 |                                                                                                       |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>SEPTICEMIA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>NEW ONSET DIABETES</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b></b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. <b></b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 | Approximate Interval Between Onset and Death<br><b>1 week.</b>                                        |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>MULTI INFARCT DEMENTIA</b><br><b>ANEMIA.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide                                                                                                                                                                                                                                                                                                                                              |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |                                                                                                       |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                               |  |                                                                                                 |                                                                                                       |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>John J. Stricker Sr. MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>201598</b>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/17/94</b>                                          |                                                                                                       |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>CLARENCE BARICOFF - ABOD 900 CATON AVE ; BAL MD 21229.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 32. REGISTRAR'S SIGNATURE<br><b>John J. Stricker Sr.</b>                                                                                                                                        |  |                                                                                                 |                                                                                                       |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Mary L. Strohmmer</i>                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                           |  | 2. DATE OF DEATH<br>MONTH <i>Nov.</i> DAY <i>16</i> YEAR <i>94</i>                                                                                                                                  |  | 3. TIME OF DEATH<br><i>7:45p</i> M                                                                  |  |
| 4. SOCIAL SECURITY NUMBER<br><i>212-220-0239</i>                                                                                                                                                                                                                                                                                                                                                                                 |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                                            |  | 6. AGE (In yrs. last birthday)<br><i>80</i> YRS.                                                                                                                                                    |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>February 19, 1914</i>                                  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>828 North Eutaw Street</i>                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                           |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Baltimore</i>                                                                                                                                             |  | 9c. COUNTY OF DEATH<br><i>--</i>                                                                    |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 10a. STATE<br><i>Maryland</i>                                                                                                                                                                                                                                                                                                                                                                                                    |  | 10b. COUNTY<br><i>Baltimore</i>                                                                                                                                                                                                                                                                                           |  | 10c. CITY, TOWN OR LOCATION<br><i>Randallstown</i>                                                                                                                                                  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><i>3454 T2 Carriage Hill Circle</i>                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                           |  | 10f. ZIP CODE<br><i>21133</i>                                                                                                                                                                       |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>United States</i>                                               |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                           |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                          |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>White</i>                             |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>1</i> College (1-4 or 5+) <i>1</i>                                                                                                                                                                                                                                                                                          |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>office worker</i>                                                                                                                                                                                     |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Maryland State</i>                                                                                                                                             |  |                                                                                                     |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>John Henry Strohmmer</i>                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                           |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Katherine Dreves</i>                                                                                                                        |  |                                                                                                     |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Mary Warfield</i>                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                           |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>16010 Four Points Bridge Road Emmittsburg, MD 21727</i>                                         |  |                                                                                                     |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Carroll Cremation, Inc. Nov. 18, 1994 Hampstead, Maryland</i>                                                                                                                                                                       |  | 20c. LOCATION — City or Town, State                                                                                                                                                                 |  |                                                                                                     |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Joseph J. Kellner</i>                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                           |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Loring Byers Funeral Directors, INC.<br/>8728 Liberty RD Randallstown, MD 21133-4784</i>                                                                     |  |                                                                                                     |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →                                                                                                                                                                                                                                                                                                                                                                |  | a. <i>Adenoid cystic carcinoma trachea</i><br>DUE TO (OR AS A CONSEQUENCE OF)                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                       |  | b. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | c. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | d. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | d. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                           |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                              |  |                                                                                                     |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <i>HOSPICE</i> |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                      |  | 28a. DATE OF INJURY (Month, Day, Year)<br><i>11/17/94</i>                                                                                                                                                                                                                                                                 |  | 28b. TIME OF INJURY<br><i>11:11</i>                                                                                                                                                                 |  | 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO            |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office, building, etc.—Specify                                                                                                                                                                                                                                     |  | 28e. DESCRIBE HOW INJURY OCCURRED<br><i>NIA</i>                                                                                                                                                     |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><i>NIA</i>          |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John Strohmmer</i>                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                           |  | 29c. LICENSE NUMBER<br><i>D34952</i>                                                                                                                                                                |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>11/17/94</i>                                              |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print)<br><i>5444 Belair Rd Baltimore Md 21206</i>                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                     |  |                                                                                                     |  |
| 31. DATE FILED (Month, Day, Year)<br><i>11/17/94</i>                                                                                                                                                                                                                                                                                                                                                                             |  | 32. REGISTRAR'S SIGNATURE<br><i>John Strohmmer</i>                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                     |  |                                                                                                     |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                        |  |                                                                                                                                                  |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Thelma <del>W.</del> Smith                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                       |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>Nov 15 1994                                                                                                                                      |  | 3. TIME OF DEATH<br>M                                                                                                                            |  |
| 4. SOCIAL SECURITY NUMBER<br>464-60-1335                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                                        |  | 6. AGE (In yrs. last birthday)<br>58 YRS.                                                                                                                                              |  | 7. DATE OF BIRTH (Month, Day, Year)<br>MAY 31 1936                                                                                               |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Johns Hopkins Hospital                                                                                                                                                                                                                              |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Balto                                                                                                                                           |  | 9c. COUNTY OF DEATH                                                                                                                              |  |
| 10a. STATE<br>MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                       |  | 10b. COUNTY<br>BALTO                                                                                                                                                                   |  | 10c. CITY, TOWN OR LOCATION<br>BALTO                                                                                                             |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                       |  | 10e. STREET AND NUMBER<br>4203 OAKFORD AVE                                                                                                                                             |  | 10f. ZIP CODE<br>21215                                                                                                                           |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                       |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                       |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>BLACK                                                                                                                    |  |                                                                                                                                                  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 10TH College (14 or 5+) HOMEMAKER                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                       |  | 16. KIND OF BUSINESS/INDUSTRY                                                                                                                                                          |  |                                                                                                                                                  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>VERNON WILSON                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                       |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>HATTIE PINDER                                                                                                                     |  |                                                                                                                                                  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>TEDDY SMITH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                                       |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4203 OAKFORD AVE BALTO, MD 21215                                                      |  |                                                                                                                                                  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                       |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>GARRISON FOREST VET 112294 OWINGS MILLS, MD                                                         |  |                                                                                                                                                  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Sola March</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                       |  | 22. NAME AND ADDRESS OF FACILITY<br>March F/H West<br>4300 Wabash Avenue Balto, Md 21215                                                                                               |  |                                                                                                                                                  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Severe ? stroke</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <i>ruptured aneurysm internal jugular vein</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <i>hypertension</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. <i>hypertension</i><br>Approximate interval between Onset and Death<br>1 MINUTE |  |                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                        |  |                                                                                                                                                  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>1 Myocardial infarction 2 CV disease M-S</i><br><i>3 RML pneumonia</i><br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                        |  |                                                                                                                                                  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <i>CAR</i> |  |                                                                                                                                                                                        |  |                                                                                                                                                  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                 |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                                |  | 28b. TIME OF INJURY<br>M                                                                                                                                                               |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                             |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                           |  |                                                                                                                                                  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                        |  |                                                                                                                                                  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>M. Purcell Staff Physician</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                       |  | 29c. LICENSE NUMBER<br>019714                                                                                                                                                          |  | 29d. DATE SIGNED (Month, Day, Year)<br>11/17/94                                                                                                  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>MICHAEL PURCELL, P/KAL 4440 Eastern Ave Md 21224</i>                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                        |  |                                                                                                                                                  |  |
| 31. DATE FILED (Month, Day, Year)<br>11/17/94 NOV 18 1994                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                       |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                                                                                        |  |                                                                                                                                                  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33951

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                                                       |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Marie V. Sporenberg</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH <i>11</i> DAY <i>15</i> YEAR <i>94</i>                                                                                                                                |  | 3. TIME OF DEATH<br><i>1052</i> M                                                           |                                                                                                       |
| 4. SOCIAL SECURITY NUMBER<br><i>218-03-0700</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><i>74</i> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH<br>MONTH <i>12</i> DAY <i>19</i> YEAR <i>1919</i>                          |                                                                                                       |
| 8. BIRTHPLACE (State or Foreign Country)<br><i>Maryland</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  | 9. COUNTY OF DEATH                                                                                                                                                                              |  |                                                                                             |                                                                                                       |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>St. Agnes Hospital</i>                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Baltimore</i>                                                                                                                                         |  |                                                                                             |                                                                                                       |
| 10a. STATE<br><i>Maryland</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  | 10b. COUNTY                                                                                                                                                                                     |  | 10c. CITY, TOWN OR LOCATION<br><i>Baltimore</i>                                             |                                                                                                       |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                                                       |
| 10e. STREET AND NUMBER<br><i>123 W. 29th Street Apt. 8H</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  | 10f. ZIP CODE<br><i>21218</i>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>United States</i>                                       |                                                                                                       |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                      |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>White</i>                     |                                                                                                       |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  | 16a. DECEDEENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Homemaker</i>                                                              |  | 16b. KING OF BUSINESS/INDUSTRY<br><i>Own Home</i>                                           |                                                                                                       |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>James Carroll</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Clara Schmidt</i>                                                                                                                       |  |                                                                                             |                                                                                                       |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Mary LS Barton</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>2154 Lorraine Ave. Baltimore, MD 21207</i>                                                  |  |                                                                                             |                                                                                                       |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                               |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Western Cemetery 11/18 Baltimore, MD</i>                                                                                                                                                                 |  | 20c. LOCATION — City or Town, State                                                                                                                                                             |  |                                                                                             |                                                                                                       |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Ambrose Funeral Home of Lansdowne<br/>2719 Hammonds Ferry Road<br/>Lansdowne, Maryland 21227</i>                                                         |  |                                                                                             |                                                                                                       |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Respiratory arrest</i><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><i>Pneumonia</i><br><i>chronic obstructive lung disease</i> |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             | Approximate interval between Onset and Death<br><i>immediate</i><br><i>1 wk</i><br><i>years</i>       |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>cardiomyopathy 2-3 years</i>                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                                                       |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                                                       |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                                                       |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide                                                                                                                                                                                                                                                       |  | 28a. DATE OF INJURY (Month, Day, Year)<br><i>NA</i>                                                                                                                                                                                                                                            |  | 28b. TIME OF INJURY<br><i>NA</i>                                                                                                                                                                |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |                                                                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 28d. DESCRIBE HOW INJURY OCCURRED<br><i>NA</i>                                                                                                                                                                                                                                                 |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><i>NA</i>                                                                                             |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><i>NA</i>   |                                                                                                       |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                                                       |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><i>Resident</i>                                                                                                                                                          |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>11/15/94</i>                                      |                                                                                                       |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 21) (Type, Print)<br><i>Jeffrey S. Miller, 900 caton Avenue Baltimore MD</i>                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                                                       |
| 31. DATE FILED (Month, Day, Year)<br><i>NOV 18 1994</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                                                                                                 |  |                                                                                             |                                                                                                       |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33952

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                                 |                                                    |                                                                                             |                                                                                                 |                                                                                                                                         |  |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|---------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Norris</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                             |                                                  | 2. DATE OF DEATH<br>MONTH <i>11</i> DAY <i>15</i> YEAR <i>1994</i>                                                                                                                              |                                                    |                                                                                             |                                                                                                 | 3. TIME OF DEATH<br><i>1:50 P.M.</i>                                                                                                    |  |  |
| 4. SOCIAL SECURITY NUMBER<br><i>213-36-9061</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                  | 6. AGE (In yrs. last birthday)<br><i>58</i> YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br><i>3-1-1936</i>                                                                                                                                          |                                                    | 8. BIRTHPLACE (State or Foreign Country)<br><i>Maryland</i>                                 |                                                                                                 |                                                                                                                                         |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>Carroll Co. Gen. Hospital</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                             |                                                  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Westminster</i>                                                                                                                                       |                                                    |                                                                                             | 9c. COUNTY OF DEATH<br><i>Carroll</i>                                                           |                                                                                                                                         |  |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                                 |                                                    |                                                                                             |                                                                                                 |                                                                                                                                         |  |  |
| 10a. STATE<br><i>Maryland</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 10b. COUNTY<br><i>Carroll</i>                                                                                                                                                                                                                                                               |                                                  | 10c. CITY, TOWN OR LOCATION<br><i>Hampstead</i>                                                                                                                                                 |                                                    |                                                                                             | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |                                                                                                                                         |  |  |
| 10e. STREET AND NUMBER<br><i>1353 North Main Street P.O. Box 40</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                             |                                                  | 10f. ZIP CODE<br><i>21074</i>                                                                                                                                                                   |                                                    | 10g. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>                                              |                                                                                                 |                                                                                                                                         |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><i>1958-1961</i>                                                                                                                            |                                                  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |                                                    |                                                                                             | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>White</i>                         |                                                                                                                                         |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i></i>                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><i>Carpenter</i>                                                                                                                                                              |                                                  |                                                                                                                                                                                                 | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Carpentry</i> |                                                                                             |                                                                                                 |                                                                                                                                         |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>John Herman Seipp</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                             |                                                  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Minnie Viola Kelbaugh</i>                                                                                                               |                                                    |                                                                                             |                                                                                                 |                                                                                                                                         |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Patricia Ellen Seipp</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |                                                  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>P.O. Box 40 Hampstead, MD. 21074</i>                                                        |                                                    |                                                                                             |                                                                                                 |                                                                                                                                         |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                          |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Evergreen Mem. Gardens 11-17-1994 Finksburg, MD.</i>                                                                                                                                                  |                                                  |                                                                                                                                                                                                 | 20c. LOCATION — City or Town, State                |                                                                                             |                                                                                                 |                                                                                                                                         |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>J. Barth Eckhardt</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                             |                                                  | 22. NAME AND ADDRESS OF FACILITY<br><i>Eckhardt Funeral Chapel<br/>3296 Charmil Dr. Manchester, Md. 21102</i>                                                                                   |                                                    |                                                                                             |                                                                                                 |                                                                                                                                         |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>s. METASTATIC LUNG CA</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                                 |                                                    |                                                                                             |                                                                                                 | Approximate Interval Between Onset and Death                                                                                            |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                                 |                                                    |                                                                                             |                                                                                                 | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                              |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                                 |                                                    |                                                                                             |                                                                                                 | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 28. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                  |                                                                                                                                                                                                 |                                                    |                                                                                             |                                                                                                 |                                                                                                                                         |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                        |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                      |                                                  | 28b. TIME OF INJURY<br><i>M</i>                                                                                                                                                                 |                                                    | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |                                                                                                 | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                       |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>David Kruter</i>                                                                                                                                                                                                                                |                                                  | 29c. LICENSE NUMBER<br><i>D35398</i>                                                                                                                                                            |                                                    | 29d. DATE SIGNED (Month, Day, Year)<br><i>11/15/94</i>                                      |                                                                                                 |                                                                                                                                         |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>DAVID KRUTER, MD 904 WASHINGTON RD SUITE D, WESTMINSTER, MD 21157</i>                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                                 |                                                    |                                                                                             |                                                                                                 |                                                                                                                                         |  |  |
| 31. DATE FILED (Month, Day, Year)<br><i>NOV 18 1994</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 32. REGISTRAR'S SIGNATURE<br><i>John Andrew Radtke</i>                                                                                                                                                                                                                                      |                                                  |                                                                                                                                                                                                 |                                                    |                                                                                             |                                                                                                 |                                                                                                                                         |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33953

1 FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                        |                                                                                                |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><u> Evelyn Zulauf Temple </u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><u> November 9, 1994 </u>                                                                                                                                                                                                                                 |  | 3. TIME OF DEATH<br><u> 7:58 A M </u>                                                                                                                                                  |                                                                                                |
| 4. SOCIAL SECURITY NUMBER<br><u> 014-38-3417 </u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><u> 82 </u> YRS.                                                                                                                                                                                                                                              |  | 7. DATE OF BIRTH (Month, Day, Year)<br><u> 4-1-12 </u>                                                                                                                                 |                                                                                                |
| 8. BIRTHPLACE (State or Foreign Country)<br><u> Maryland </u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                |  | 9a. FACILITY NAME (If not institution, give street and number)<br><u> Lorien Riverside Nursing Home </u>                                                                                                                                                                                        |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><u> Baltimore </u>                                                                                                                              |                                                                                                |
| 9c. COUNTY OF DEATH<br><u> Harford </u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                |  | 10a. STATE<br><u> Md. </u>                                                                                                                                                                                                                                                                      |  | 10b. COUNTY<br><u> HARFORD </u>                                                                                                                                                        |                                                                                                |
| 10c. CITY, TOWN OR LOCATION<br><u> Forest Hill </u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                             |  | 10e. STREET AND NUMBER<br><u> 309 Red Pump Road </u>                                                                                                                                   |                                                                                                |
| 10f. ZIP CODE<br><u> 21014 </u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                |  | 10g. CITIZEN OF WHAT COUNTRY?<br><u> United States </u>                                                                                                                                                                                                                                         |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |                                                                                                |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                                                                                             |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><u> White </u>                                                                                                           |                                                                                                |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u> 12 </u> College (1-4 or 5+) <u> </u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><u> Teacher </u>                                                                                                                                                                  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><u> Balto. Co. </u>                                                                                                                                  |                                                                                                |
| 17. FATHER'S NAME (First, Middle, Last)<br><u> Benjamin Franklin ZULAUF </u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><u> MARY Alice Walther </u>                                                                                                                                                                                                                |  |                                                                                                                                                                                        |                                                                                                |
| 19a. INFORMANT'S NAME (Type/Print)<br><u> Deanna Temple </u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u> 2403 Oak Manor Rd. Edgemere, Md 21219 </u>                                                                                                                                                 |  |                                                                                                                                                                                        |                                                                                                |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><u> Fork United Methodist Cen </u>                                                                                                                                                                           |  | 20c. LOCATION — City or Town, State<br><u> Fork, Md </u>                                                                                                                               |                                                                                                |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><u> [Signature] </u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><u> EVANS FUNERAL Chapel </u><br><u> 8800 HARFORD Rd Balto. Md. 21234 </u>                                                                                                                                                                                  |  |                                                                                                                                                                                        |                                                                                                |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u> CARDIAC DYSRHYTHMIA </u><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br><u> MYOCARDIAL INFARCTION </u><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br><u> ASCVD </u><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                        | Approximate Interval Between Onset and Death                                                   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                        | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                        |                                                                                                |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                        |                                                                                                |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                        |                                                                                                |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                          |  | 28b. TIME OF INJURY<br><u> M </u>                                                                                                                                                      |                                                                                                |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                               |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                           |                                                                                                |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                    |  |                                                                                |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                        |                                                                                                |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><u> [Signature] </u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                |  | 29c. LICENSE NUMBER<br><u> H41069 </u>                                                                                                                                                                                                                                                          |  | 29d. DATE SIGNED (Month, Day, Year)<br><u> 11/9/94 </u>                                                                                                                                |                                                                                                |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><u> Dr. Stanley Kman 1308 Business Center Way Edgewood, Md 21040 </u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                        |                                                                                                |
| 31. DATE FILED (Month, Day, Year)<br><u> NOV 18 1994 </u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                |  | 32. REGISTRAR'S SIGNATURE<br><u> [Signature] </u>                                                                                                                                                                                                                                               |  |                                                                                                                                                                                        |                                                                                                |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





94 33954

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                             |  |                                                                                                     |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>William E Tucker</b>                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 17 1994</b>                                                                                                                                                               |  | 3. TIME OF DEATH<br><b>2:15 AM</b>                                                                  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-56-4123</b>                                                                                                                                                                                                                                                                                                                                                                                     |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                                                                                                                                                             |  | 6. AGE (In yrs. last birthday)<br><b>45</b> YRS.                                                                                                                                                                            |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>06-01-49</b>                                           |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>GOOD SAMARITAN HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>                                                                                                                                                                |  | 9c. COUNTY OF DEATH<br><b>NONE</b>                                                                  |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                             |  |                                                                                                     |  |
| 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                       |  | 10b. COUNTY<br><b>NONE</b>                                                                                                                                                                                                                                                                                 |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE CITY</b>                                                                                                                                                                        |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>6231 PIONEER DRIVE</b>                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |  | 10f. ZIP CODE<br><b>21214</b>                                                                                                                                                                                               |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>UNITED STATES</b>                                               |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                              |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                           |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: <b>AFRICAN AMERICAN</b> |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>AFRICAN AMERICAN</b>                  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4 YEARS</b> College (1-4 or 5+) <b>4 YEARS</b>                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>COLLECTION MANAGER</b>                                                                                  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>SAVINGS AND LOAN CO.</b>                                       |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>MATTHEW TUCKER</b>                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>ROSA LEE MARKS</b>                                                                                                                                                  |  |                                                                                                     |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>DARLENE TUCKER</b>                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6231 PIONEER DRIVE BALTO, MD. 21214</b>                                                                                 |  |                                                                                                     |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                     |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery or other place)<br><b>DULANEY VALLEY MEM. GARDEN BALTO, CO, MD.</b>                                                                                                                                                                                   |  | 20c. LOCATION — City or Town, State<br><b>BALTO, CO, MD.</b>                                                                                                                                                                |  | 20d. DATE<br><b>11/21/94</b>                                                                        |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Calvin B. Scruggs Jr.</i>                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br><b>CALVIN B. SCRUGGS FUNERAL HOME<br/>1412 E. PRESTON ST. BALTO, MD. 21213</b>                                                                                                          |  |                                                                                                     |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                             |  |                                                                                                     |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                             |  |                                                                                                     |  |
| a. <b>Acute kidney and liver failure /</b><br>DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                             |  |                                                                                                     |  |
| b. <b>Severe Metabolic acidosis</b><br>DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                             |  |                                                                                                     |  |
| c. <b>Metastatic cancer of colon</b><br>DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                             |  |                                                                                                     |  |
| d.                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                             |  |                                                                                                     |  |
| Approximate Interval Between Onset and Death<br><b>one month</b><br><b>one day</b>                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                             |  |                                                                                                     |  |
| Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                             |  |                                                                                                     |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes Mellitus</b>                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                             |  |                                                                                                     |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                               |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                                             |  |                                                                                                     |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide                                                                                                                                           |  | 28a. DATE OF INJURY<br>(Month, Day, Year)                                                                                                                                                                                                                                                                  |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                                                    |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            |  | 28e. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                           |  |                                                                                                     |  |
| 29a. CERTIFIER<br>(Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John D. ...</i>                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>P 7619</b>                                                                                                                                                                                        |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>November-18-1994</b>                                      |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Ali Saifi, The Good Samaritan Hospital of Maryland, 5601 Loch Raven Blvd, Baltimore, MD 21239</b>                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                             |  |                                                                                                     |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                             |  | 32. REGISTRAR'S SIGNATURE<br><i>John D. ...</i>                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                             |  |                                                                                                     |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



21

94 33955

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                 |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                            |  |                                                    |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Margaret Tribull                                                                                                                                                                                                                                    |  |                                                                                |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>November 9, 1994                                                                                                                                                                                                                                                                     |  |                                                    |  | 3. TIME OF DEATH<br>1:20 A M                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |
| 4. SOCIAL SECURITY NUMBER<br>218 64 4740                                                                                                                                                                                                                                                        |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>86 YRS.                                                                                                                                                                                                                                                                                  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>10 23 08 |  | 8. BIRTHPLACE (State or Foreign Country)<br>Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Church Hospital                                                                                                                                                                                                               |  |                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City                                                                                                                                                                                                                                                                      |  |                                                    |  | 9c. COUNTY OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |
| 10a. STATE<br>Md.                                                                                                                                                                                                                                                                               |  |                                                                                |  | 10b. COUNTY                                                                                                                                                                                                                                                                                                                |  |                                                    |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore City                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                             |  |                                                                                |  | 10e. STREET AND NUMBER<br>3027 Elliott Street                                                                                                                                                                                                                                                                              |  |                                                    |  | 10f. ZIP CODE<br>21224                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                                                                                                                                                                            |  |                                                                                |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                     |  |                                                    |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                                                                                             |  |                                                                                |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                                                                                                                                                                                                                                                        |  |                                                    |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Housework                                                                                                                                                                      |  |                                                                                |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Atr Home                                                                                                                                                                                                                                                                                 |  |                                                    |  | 17. FATHER'S NAME (First, Middle, Last)<br>John F. Amttmann                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Cora                                                                                                                                                                                                                                       |  |                                                                                |  | 19. INFORMANT'S NAME (Type/Print)<br>Anna J. Starr                                                                                                                                                                                                                                                                         |  |                                                    |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>225 N. Linwood Ave. Balto., Md. 21224                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                 |  |                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Most Holy Redeemer Cem. 1112-94 Balto., Md.                                                                                                                                                                                             |  |                                                    |  | 20c. LOCATION — City or Town, State                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Charles S. Zeiler                                                                                                                                                                                                                                  |  |                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br>Charles S. Zeiler & Son Inc.<br>901 S. Conkling St. Balto., Md.                                                                                                                                                                                                                        |  |                                                    |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Congestive Heart Failure<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                       |  |                                                                                |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                     |  |                                                    |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                |  | 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Other |  |                                                    |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |
| 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                           |  |                                                                                |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                       |  |                                                    |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                          |  |                                                                                |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                               |  |                                                    |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                          |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>HOUSE OFFICER                                                                                                                                                                                                                                          |  |                                                                                |  | 29c. LICENSE NUMBER<br>D-40521                                                                                                                                                                                                                                                                                             |  |                                                    |  | 29d. DATE SIGNED (Month, Day, Year)<br>11/9/94                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>DR. OCHANEY 100 NORTH BROADWAY BALTIMORE, MD 21231                                                                                                                                                       |  |                                                                                |  | 31. DATE FILED (Month, Day, Year)<br>NOV 18 1994                                                                                                                                                                                                                                                                           |  |                                                    |  | 32. REGISTRAR'S SIGNATURE<br>John H. H. H.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Leroy Taylor</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov. 16, 1994</b>                                                                                                                                      |  | 3. TIME OF DEATH<br><b>1:25 P M</b>                                                             |  |
| 4. SOCIAL SECURITY NUMBER<br><b>231-14-1486</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>74</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>JUL 4, 1920</b>                                    |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>MARYLAND GENERAL HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>                                                                                                                                    |  | 9c. COUNTY OF DEATH<br><b>n/a</b>                                                               |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 10b. COUNTY<br><b>n/a</b>                                                                                                                                                                                                                                                                      |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE CITY</b>                                                                                                                                            |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>1805 E. NORTH AVENUE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  | 10f. ZIP CODE<br><b>21213</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>UNITED STATES</b>                                           |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6 TH</b> College (1-4 or 5+) <b>—</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  | 16. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>CRAN OPERATOR</b>                                                            |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>AARMCO STEEL COMPANY</b>                                   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>DAVID TAYLOR</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MALINDA NEAL</b>                                                                                                                        |  |                                                                                                 |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>LEROY A. TAYLOR</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4000 NORFOLK AVENUE, BALTIMORE, MD 21216</b>                                                |  |                                                                                                 |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                               |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>BALTIMORE CEMETERY 11-21</b>                                                                                                                                                                             |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MD</b>                                                                                                                                     |  |                                                                                                 |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Bernard O Johnson</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>WM. C. MARCH FH.-1101 E. NORTH AVENUE</b>                                                                                                                |  |                                                                                                 |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute Myocardial Infarction</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. <b>Severe Coronary Artery Disease</b><br>c.<br>d.<br>Approximate Interval Between Onset and Death <b>unknown</b> |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>End Stage Renal Disease, Nephrotic Syndrome, GI Bleed, Ischemic Colitis</b>                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                           |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
| 28d. DESCRIBE NOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  | 28e. PLACE OF INJURY — At home, term, street, tectory, office building, etc. (Specify)                                                                                                          |  |                                                                                                 |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Joseph Nkwanyou</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>D30309</b>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/16/94</b>                                          |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Joseph Nkwanyou, M.D. c/o Maryland General Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  | 32. REGISTRAR'S SIGNATURE<br><i>Jalil Anderson-Rasell</i>                                                                                                                                       |  |                                                                                                 |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                                 |                                                              |                                                                                             |  |                                                                                                       |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>William A. Thompson</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |                                                  | 2. DATE OF DEATH<br>MONTH <i>11</i> DAY <i>18</i> YEAR <i>1994</i>                                                                                                                              |                                                              | 3. TIME OF DEATH<br><i>1:45 A</i> M                                                         |  |                                                                                                       |  |
| 4. SOCIAL SECURITY NUMBER<br><i>299-28-8228</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     | 6. AGE (In yrs. last birthday)<br><i>58</i> YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br><i>11-18-36</i>                                                                                                                                          | 8. BIRTHPLACE (State or Foreign Country)<br><i>Cleveland</i> |                                                                                             |  |                                                                                                       |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>Hyattsville Health Care Center</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |                                                  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Hyattsville Md.</i>                                                                                                                                   |                                                              | 9c. COUNTY OF DEATH<br><i>P.G.</i>                                                          |  |                                                                                                       |  |
| 10a. STATE<br><i>MD</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 10b. COUNTY<br><i>Prince Geo County</i>                                                                                                                                                                                                                                                        |                                                  | 10c. CITY, TOWN OR LOCATION<br><i>Bethesda</i>                                                                                                                                                  |                                                              | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO        |  |                                                                                                       |  |
| 10e. STREET AND NUMBER<br><i>#3 POOK HILL RD #717</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |                                                  | 10f. ZIP CODE<br><i>20814</i>                                                                                                                                                                   |                                                              | 10g. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>                                                 |  |                                                                                                       |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                   |                                                  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |                                                              | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>White</i>                     |  |                                                                                                       |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. DO NOT use retired.)                                                                                                                                                                                     |                                                  | 15b. KIND OF BUSINESS/INDUSTRY                                                                                                                                                                  |                                                              |                                                                                             |  |                                                                                                       |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Richard M. Thompson</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |                                                  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Jaqueline L. Thompson</i>                                                                                                               |                                                              |                                                                                             |  |                                                                                                       |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Robert R. Thompson</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |                                                  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>131 East 205, Euclid, Ohio 44127</i>                                                        |                                                              |                                                                                             |  |                                                                                                       |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>In state removal</i>                                                                                                                                                                                     |                                                  | DATE                                                                                                                                                                                            |                                                              | 20c. LOCATION — City or Town, State                                                         |  |                                                                                                       |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Ronald Wade, Dir</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |                                                  | 22. NAME AND ADDRESS OF FACILITY<br><i>State Anatomy Board<br/>655W. Baltimore St, Balto, MD 21201</i>                                                                                          |                                                              |                                                                                             |  |                                                                                                       |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. <i>Ischemic heart disease</i><br>b. <i>Sudden death</i><br>c. <i>In situ carcinoma</i><br>d. <i>Acquired immune deficiency syndrome</i><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Chronic obstructive pulmonary disease</i> |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                                 |                                                              |                                                                                             |  | Approximate Interval Between Onset and Death<br><i>3 hr</i><br><i>sub</i><br><i>sub</i><br><i>sub</i> |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                  |                                                                                                                                                                                                 |                                                              |                                                                                             |  |                                                                                                       |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |                                                  | 28b. TIME OF INJURY<br><i>M</i>                                                                                                                                                                 |                                                              | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                     |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |                                                  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                    |                                                              |                                                                                             |  |                                                                                                       |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                                 |                                                              |                                                                                             |  |                                                                                                       |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John D. ...</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |                                                  | 29c. LICENSE NUMBER<br><i>DOM 99</i>                                                                                                                                                            |                                                              | 29d. DATE SIGNED (Month, Day, Year)<br><i>11/18/94</i>                                      |  |                                                                                                       |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                                 |                                                              |                                                                                             |  |                                                                                                       |  |
| 31. DATE FILED (Month, Day, Year)<br><i>NOV 18 1994</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |                                                  | 32. REGISTRAR'S SIGNATURE<br><i>John D. ...</i>                                                                                                                                                 |                                                              |                                                                                             |  |                                                                                                       |  |

RECEIVED  
JAN 10 1964

RECEIVED  
JAN 10 1964



94 33958

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                     |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>THELMA CHRISTINA VIOL</b>                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 18, 1994</b>                                                                                                                                                                                                                                             |  | 3. TIME OF DEATH<br><b>7:00A</b> M                                                                  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-14-5228</b>                                                                                                                                                                                                                                                                                                                                                                                  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                   |  | 6. AGE (In yrs. last birthday)<br><b>84</b> YRS.                                                                                                                                                                                                                                                           |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>December 29, 1909</b>                                     |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                     |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Glen Meadows</b>                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Glen Arm</b>                                                                                                                                                                                                                                                     |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>                                                             |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                     |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  | 10b. COUNTY<br><b>Baltimore</b>                                                                                                                  |  | 10c. CITY, TOWN OR LOCATION<br><b>Glen Arm</b>                                                                                                                                                                                                                                                             |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>11630 Glen Arm Road</b>                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                  |  | 10f. ZIP CODE<br><b>21057</b>                                                                                                                                                                                                                                                                              |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                         |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                           |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                                                                                                        |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                          |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Teacher</b>                                                                                                                                                                               |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Private School</b>                                             |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Frederick J. Viol</b>                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary A. Knieling</b>                                                                                                                                                                                                                               |  |                                                                                                     |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>V.C.O'Brien</b>                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2428 Chetwood Circle Lutherville, Maryland 21093</b>                                                                                                                                                   |  |                                                                                                     |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Greenmount Cemetery</b>                                    |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Maryland</b>                                                                                                                                                                                                                                          |  |                                                                                                     |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Bernis Stulen</i>                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Mitchell-Wiedefeld Home</b><br><b>6500 York Road Baltimore, Maryland 21212</b>                                                                                                                                                                                      |  |                                                                                                     |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                        |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                     |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ACUTE MYOCARDIAL INFARCTION</b>                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                     |  |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                          |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                     |  |
| a. <b>ANGINA</b> DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                     |  |
| b. <b>INSULIN DEPENDENT DIABETES</b> DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                     |  |
| c. <b>RENAL FAILURE</b> DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                     |  |
| d. <b>RENAL FAILURE</b>                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                     |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                     |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                     |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                     |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                     |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                     |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                        |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                           |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                                                                                                                            |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                  |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                          |  |                                                                                                     |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                     |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Marcio M. Menendez MD</i>                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                  |  | 29c. LICENSE NUMBER<br><b>D-07697</b>                                                                                                                                                                                                                                                                      |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>November 18, 1994</b>                                     |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Marcio M. Menendez 7505 Osler Drive Towson, Maryland 21204</b>                                                                                                                                                                                                                                                                         |  |                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                     |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                  |  | 32. REGISTRAR'S SIGNATURE<br><i>Johi...</i>                                                                                                                                                                                                                                                                |  |                                                                                                     |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

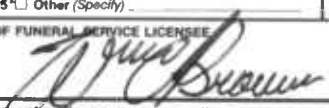
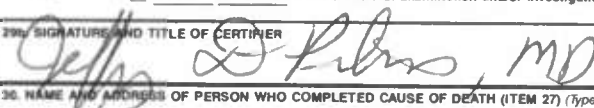

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33959

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JANICE WEBB</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH <b>NOVEMBER</b> DAY <b>15</b> , YEAR <b>1994</b>                                                                                                                      |  | 3. TIME OF DEATH<br><b>10:01 a. M</b>                                                           |                                                                                                       |
| 4. SOCIAL SECURITY NUMBER<br><b>212-74-0402</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>37</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>10-05-57</b>                                          |                                                                                                       |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>THE JOHNS HOPKINS HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>                                                                                                                                    |  | 9c. COUNTY OF DEATH<br><b>Maryland</b>                                                          |                                                                                                       |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| 10a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 10b. COUNTY                                                                                                                                                                                                                                                                                    |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                                                                                                                                                 |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |                                                                                                       |
| 10e. STREET AND NUMBER<br><b>740 Poplar Grove St.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  | 10f. ZIP CODE<br><b>21216</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>                                                   |                                                                                                       |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                         |                                                                                                       |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>HouseKeeping</b>                                                                                                                                                           |  | 16b. KIND OF BUSINESS/INDUSTRY                                                                                                                                                                  |  |                                                                                                 |                                                                                                       |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Percy Webb</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Lillian Stewart Thompson</b>                                                                                                            |  |                                                                                                 |                                                                                                       |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Lillian Thompson</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>740 Poplar Grove St. Balto., MD. 21216</b>                                                  |  |                                                                                                 |                                                                                                       |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metro 11/19 Balto., MD.</b>                                                                                                                                                                              |  | 20c. LOCATION — City or Town, State                                                                                                                                                             |  |                                                                                                 |                                                                                                       |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>William C. Brown Community F/H<br/>1206 W. North Ave.</b>                                                                                                |  |                                                                                                 |                                                                                                       |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. <b>Aortic insufficiency</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>Bacterial endocarditis</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>Intravenous drug use</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 | Approximate Interval Between Onset and Death<br><b>2 w</b><br><b>4 w</b><br><b>10 y</b>               |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>multiple cerebral septic emboli, renal failure</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                             |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |                                                                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                 |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |                                                                                                       |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                           |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                                                                                                                                                                   |  | 29c. LICENSE NUMBER<br><b>M0263</b>                                                                                                                                                             |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/15/94</b>                                          |                                                                                                       |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                       |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                |  |                                                                                                 |                                                                                                       |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33960

Items 1 &amp; 17, g-717, 11-18-94, per F.H., dr

1 -  
FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                                    |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><u>Lillie Watson</u> Lillie Mae Walston                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                     |  | 2. DATE OF DEATH<br>MONTH <u>11</u> DAY <u>15</u> YEAR <u>94</u>                                                                                                                                |  | 3. TIME OF DEATH<br><u>320 A</u> M                                                                 |  |
| 4. SOCIAL SECURITY NUMBER<br><u>217-22-9523</u>                                                                                                                                                                                                                                                                                                                                                                   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                          |  | 6. AGE (In yrs. last birthday)<br><u>75</u> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><u>06 07 19</u>                                          |  |
| 8. FACILITY NAME (If not institution, give street and number)<br><u>Mercy Medical Center</u>                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                     |  | 9. CITY, TOWN OR LOCATION OF DEATH<br><u>Baltimore</u>                                                                                                                                          |  | 10. BIRTHPLACE (State or Foreign Country)<br><u>N.C.</u>                                           |  |
| 10a. STATE<br><u>md.</u>                                                                                                                                                                                                                                                                                                                                                                                          |  | 10b. COUNTY                                                                                                                                                                                                                                                                         |  | 10c. CITY, TOWN OR LOCATION<br><u>BALTO.</u>                                                                                                                                                    |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO    |  |
| 10e. STREET AND NUMBER<br><u>1720 E. Preston St.</u>                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                     |  | 10f. ZIP CODE<br><u>21213</u>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>                                                       |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                    |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                        |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yea or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><u>BLACK</u>                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input checked="" type="checkbox"/> College (14 or 5+) <input type="checkbox"/>                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                     |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><u>Housewife</u>                                                               |  | 16b. KIND OF BUSINESS/INDUSTRY                                                                     |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><u>NORTH FLET</u> Northflet Verleney                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                     |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><u>Lizzie Power</u>                                                                                                                        |  |                                                                                                    |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><u>Joe Walston</u>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                     |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>1720 E. Preston St. BALTO md 21213</u>                                                      |  |                                                                                                    |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                             |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><u>BALTO Come</u>                                                                                                                                                                                |  | 20c. LOCATION — City or Town, State<br><u>Phy BALTO md</u>                                                                                                                                      |  | 20d. NAME AND ADDRESS OF FACILITY<br><u>Betts Funeral Home</u><br><u>1129 N. CAROLINE ST 21213</u> |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><u>Bettina Betts</u>                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                     |  | 22. NAME AND ADDRESS OF FACILITY                                                                                                                                                                |  |                                                                                                    |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                                    |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Cardiac Arrhythmia</u>                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                                    |  |
| DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                                    |  |
| Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                                    |  |
| b. <u>Severe Dehydration and Weight loss</u>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                                    |  |
| DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                                    |  |
| c. _____                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                                    |  |
| DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                                    |  |
| d. _____                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                                    |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                                    |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                                    |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                                    |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                                    |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                    |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                |  | 28a. DATE OF INJURY<br>(Month, Day, Year)                                                                                                                                                                                                                                           |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                               |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                   |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                 |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                              |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                    |  | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)                       |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                                    |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><u>Dwight L. Lyle MD, Resident</u>                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                     |  | 29c. LICENSE NUMBER<br><u>P08176</u>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><u>11/15/94</u>                                             |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                 |  |                                                                                                    |  |
| 31. DATE FILED (Month, Day, Year)<br><u>NOV 18 1994</u>                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                     |  | 32. REGISTRAR'S SIGNATURE<br><u>John B. ...</u>                                                                                                                                                 |  |                                                                                                    |  |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached from this certificate and filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



94 33961

Item#7 Per F.H. Film#717 11/18/94 R.M.

1 -  
FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                   |  |                                                                                                 |                                                                                                                                                                     |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Audrey Watts</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |  | 2. DATE OF DEATH<br>MONTH <b>Nov</b> DAY <b>14</b> YEAR <b>1994</b>                                                                                                                               |  | 3. TIME OF DEATH<br>M                                                                           |                                                                                                                                                                     |
| 4. SOCIAL SECURITY NUMBER<br><b>212-34-5821</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 5. SEX<br>1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                               |  | 6. AGE (In yrs. last birthday)<br><b>58</b> YRS.                                                                                                                                                  |  | 7. DATE OF BIRTH<br>MONTH <b>MARCH</b> DAY <b>10</b> YEAR <b>1936</b>                           |                                                                                                                                                                     |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Lorien N/H</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Columbia</b>                                                                                                                                            |  | 9c. COUNTY OF DEATH<br><b>HOWARD</b>                                                            |                                                                                                                                                                     |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                   |  |                                                                                                 |                                                                                                                                                                     |
| 10a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 10b. COUNTY                                                                                                                                                                                                                                                                                                |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTO</b>                                                                                                                                                       |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |                                                                                                                                                                     |
| 10e. STREET AND NUMBER<br><b>1938 FEATHERBED LANE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |  | 10f. ZIP CODE<br><b>21207</b>                                                                                                                                                                     |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>                                                   |                                                                                                                                                                     |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                           |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                         |                                                                                                                                                                     |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>12TH</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOUSEWIFE</b>                                                                                                                                                                          |  | 16b. KIND OF BUSINESS/INDUSTRY                                                                                                                                                                    |  |                                                                                                 |                                                                                                                                                                     |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JAMES FREDERICK NEAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>ADDIE BARNES</b>                                                                                                                          |  |                                                                                                 |                                                                                                                                                                     |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MONICA WATTS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1643 N. AISQUITH ST BALTO, MD 21202</b>                                                       |  |                                                                                                 |                                                                                                                                                                     |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, funeral home, etc.)<br><b>KING MEMORIAL PARK</b>                                                                                                                                                                                                     |  | 20c. DATE<br><b>11/18/94</b>                                                                                                                                                                      |  | 20d. LOCATION (City or Town, State)<br><b>RANDALLSTOWN, MD</b>                                  |                                                                                                                                                                     |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Sola March</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br><b>March F/H West</b><br><b>4300 Wabash Avenue Balto, Md 21215</b>                                                                                            |  |                                                                                                 |                                                                                                                                                                     |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>probable breast carcinoma</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                   |  |                                                                                                 | Approximate Interval Between Onset and Death                                                                                                                        |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Arteriosclerosis, Cerebrovascular disease</i>                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                   |  |                                                                                                 | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                           |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                   |  |                                                                                                 | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br><i>NA</i> |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                   |  |                                                                                                 |                                                                                                                                                                     |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                     |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                          |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |                                                                                                                                                                     |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  | 28e. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                                     |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                            |  | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                      |  |                                                                                                 |                                                                                                                                                                     |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                   |  |                                                                                                 |                                                                                                                                                                     |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Ruback Holenduchet</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  | 29c. LICENSE NUMBER<br><b>D31575</b>                                                                                                                                                              |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/15/94</b>                                          |                                                                                                                                                                     |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>KODRUSSETZ 9501 Old Annapolis Rd Ellicott City MD 21042</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                   |  |                                                                                                 |                                                                                                                                                                     |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                                                                                                   |  |                                                                                                 |                                                                                                                                                                     |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |                                                                                                       |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>James WRIGHT</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 13, 1994</b>                                                                                                                                  |  | 3. TIME OF DEATH<br><b>11:10 am.</b>                                                                                                                                           |                                                                                                       |
| 4. SOCIAL SECURITY NUMBER<br><b>213-32-1627</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>58 YRS.</b>                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Feb 28, 1936</b>                                                                                                                     |                                                                                                       |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Georgia</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Franklin Square Hospital</b>                                                                                               |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>                                                                                                                        |                                                                                                       |
| 9c. COUNTY OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  | 10a. STATE<br><b>Maryland</b>                                                                                                                                                                   |  | 10b. COUNTY<br><b>Baltimore</b>                                                                                                                                                |                                                                                                       |
| 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                 |  | 10e. STREET AND NUMBER<br><b>3315 Burleith Avenue</b>                                                                                                                          |                                                                                                       |
| 10f. ZIP CODE<br><b>21215</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                     |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |                                                                                                       |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>                                                                                                     |                                                                                                       |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>High School</b> College (1-4 or 5+) <b>College</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Painter</b>                                                                    |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Bethlehem Steel Corporation</b>                                                                                                           |                                                                                                       |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Caper Capes Wright</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Gussie Kirkland</b>                                                                                                                     |  |                                                                                                                                                                                |                                                                                                       |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Elouise Wright</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3315 Burleith Avenue Baltimore, MD 21215</b>                                                |  |                                                                                                                                                                                |                                                                                                       |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metro Crematory 11/19</b>                                                                                 |  | 20c. LOCATION — City or Town, State<br><b>Catonsville, Maryland</b>                                                                                                            |                                                                                                       |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Vernon R. Bailey</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>F. Nutter Funeral Homes, Inc<br/>2501 Gwynns Falls Parkway<br/>Baltimore, Maryland 21216</b>                                                             |  |                                                                                                                                                                                |                                                                                                       |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. End Stage Lung Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>b. Cor Pulmonale</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d.</b> |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                | Approximate Interval Between Onset and Death<br><b>2 years</b>                                        |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |                                                                                                       |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |                                                                                                       |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |                                                                                                       |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                               |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                    |                                                                                                       |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |                                                                                                       |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>V. SIVANNY D.</b>                                                                                                                                                                                                                                  |  | 29c. LICENSE NUMBER<br><b>D23424</b>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/16/94</b>                                                                                                                         |                                                                                                       |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>V. SIVANNY D., 1576 HERRITT BLVD, Baltimore, MD 21222.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |                                                                                                       |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 32. REGISTRAR'S SIGNATURE<br><b>John Decker Randall</b>                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                 |  |                                                                                                                                                                                |                                                                                                       |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33963

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                       |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>PATRICIA CAROL Warner</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 10, 1994</b>                                                                                                                                  |  | 3. TIME OF DEATH<br><b>0630</b>                                                                       |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-50-7572</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>47</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>June 30, 1947</b>                                           |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>PENINSULA REGIONAL MEDICAL CENTER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>SALISBURY</b>                                                                                                                                         |  | 9c. COUNTY OF DEATH<br><b>WICOMICO</b>                                                                |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                       |  |
| 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 10b. COUNTY<br><b>WORCHESTER</b>                                                                                                                                                                                                                                                               |  | 10c. CITY, TOWN OR LOCATION<br><b>SNOW HILL</b>                                                                                                                                                 |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO       |  |
| 10e. STREET AND NUMBER<br><b>4622 NASSAWANGO ROAD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  | 10f. ZIP CODE<br><b>21863</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                        |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                               |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b><br>College (1-4 or 5+) <b>PROPERTY MANAGER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>PROPERTY MANAGER</b>                                                                                                                                                       |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>REAL ESTATE MANAGEMENT</b>                                                                                                                                 |  |                                                                                                       |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>ROBERT MCCLARY HAMMOND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>EDNA P. WILSON</b>                                                                                                                      |  |                                                                                                       |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>JAMES C. WARNER (HUSBAND)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4622 NASSAWANGO ROAD SALISBURY MARYLAND 21863</b>                                           |  |                                                                                                       |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                     |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>DRUID RIDGE CEMETERY 11-14-94</b>                                                                                                                                                                        |  | DATE<br><b>11-14-94</b>                                                                                                                                                                         |  | 20c. LOCATION — City or Town, State<br><b>PIKESVILLE MARYLAND</b>                                     |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>LEROY M &amp; RUSSELL C WITZKE FUNERAL HOMES<br/>1630 EDMONDSON AVENUE CATONSVILLE MARYLAND</b>                                                          |  |                                                                                                       |  |
| 23. PART I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>OVARIAN CARCINOMA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  | Approximate Interval Between Onset and Death<br><b>3 yrs</b>                                          |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>COLEL OBSTRUCTION FROM CARCINOMATOSIS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                       |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 28. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                       |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                        |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                      |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                          |  |                                                                                                       |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                       |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                              |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>                                                                                                                                                                                                                                    |  | 29c. LICENSE NUMBER<br><b>D41567</b>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/10/94</b>                                                |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>NICHOLAS J. DUDAS 145 E. CARROLL ST SALISBURY, MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                       |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                       |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33964

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                 |  |                                                                                      |  |                                                                                                                                             |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Charlotte Brehm Wine</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                         |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11-17-1994</b>                                                                                                                                         |  |                                                                                      |  | 3. TIME OF DEATH<br><b>0705</b> M                                                                                                           |  |
| 4. SOCIAL SECURITY NUMBER<br><b>213-12-7786</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                          |  | 6. AGE (In yrs. last birthday)<br><b>77</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>10-17-1917</b>                             |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                                                                                 |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Carroll Co. Gen. Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                         |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Westminster</b>                                                                                                                                       |  |                                                                                      |  | 9c. COUNTY OF DEATH<br><b>Carroll</b>                                                                                                       |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                 |  |                                                                                      |  |                                                                                                                                             |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 10b. COUNTY<br><b>Carroll</b>                                                                                                                                                                                                                                                                           |  | 10c. CITY, TOWN OR LOCATION<br><b>Manchester</b>                                                                                                                                                |  |                                                                                      |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                         |  |
| 10e. STREET AND NUMBER<br><b>2834 Traceys Mill Rd.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                         |  | 10f. ZIP CODE<br><b>21102</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                       |  |                                                                                                                                             |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                        |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |                                                                                      |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                     |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>1</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                         |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Supervisor</b>                                                                 |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Book Co.</b>                                    |  |                                                                                                                                             |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William S. Brehm</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                         |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Alletta B. Albaugh</b>                                                                                                                  |  |                                                                                      |  |                                                                                                                                             |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Guy E. Wine</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                         |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2834 Traceys Mill Rd. Manchester, MD. 21102</b>                                             |  |                                                                                      |  |                                                                                                                                             |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>John Luther Miller Cem. 11-19-1994 Westminster, MD.</b>                                                                                                                                                           |  |                                                                                                                                                                                                 |  | 20c. LOCATION — City or Town, State                                                  |  |                                                                                                                                             |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>J. Eckhardt</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                         |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Eckhardt Funeral Chapel<br/>3296 Charmil Dr. Manchester, MD. 21102</b>                                                                                   |  |                                                                                      |  |                                                                                                                                             |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><b>a. Ventricular fibrillation</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. Acute myocardial infarction</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                 |  |                                                                                      |  | Approximate Interval Between Onset and Death<br><b>instant</b><br><b>instant</b>                                                            |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                 |  |                                                                                      |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                              |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                 |  |                                                                                      |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                      |  |                                                                                                                                             |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                           |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                  |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                        |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                           |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                          |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Chitra Cheddu Naganna</b>                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                 |  | 29c. LICENSE NUMBER<br><b>D18200</b>                                                 |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11-17-94</b>                                                                                      |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>CHITRACHEDU NAGANNA 700 Kpode Rd Westminster 21157</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                 |  |                                                                                      |  |                                                                                                                                             |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 18 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                         |  | 32. REGISTRAR'S SIGNATURE<br><b>John H. ...</b>                                                                                                                                                 |  |                                                                                      |  |                                                                                                                                             |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33965

FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |                                                                                                       |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>WARD Elizabeth Jane</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                            |  | 2. DATE OF DEATH<br>MONTH <i>11</i> DAY <i>2</i> YEAR <i>94</i>                                                                                                                                                                                                                                |  | 3. TIME OF DEATH<br><i>10:45 A.M.</i>                                                                                                                                          |                                                                                                       |
| 4. SOCIAL SECURITY NUMBER<br><i>558-70-2186</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><i>83</i> YRS.                                                                                                                                                                                                                                               |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>10/13/08</i>                                                                                                                      |                                                                                                       |
| 8. BIRTHPLACE (State or Foreign Country)<br><i>Ohio</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                            |  | 9a. FACILITY NAME (If not institution, give street and number)<br><i>MERIDIAN COORSICA HILLS N.H.</i>                                                                                                                                                                                          |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>CENTREVILLE MD</i>                                                                                                                   |                                                                                                       |
| 9c. COUNTY OF DEATH<br><i>QUEEN ANNE CO.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                            |  | 10a. STATE<br><i>Maryland</i>                                                                                                                                                                                                                                                                  |  | 10b. COUNTY<br><i>Queen Anne Co</i>                                                                                                                                            |                                                                                                       |
| 10c. CITY, TOWN OR LOCATION<br><i>Centreville</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                            |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                           |  | 10e. STREET AND NUMBER<br><i>PO Box 50</i>                                                                                                                                     |                                                                                                       |
| 10f. ZIP CODE<br><i>21617</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                            |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>                                                                                                                                                                                                                                                    |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |                                                                                                       |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><i>no</i>                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                            |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                                |  |                                                                                                                                                                                |                                                                                                       |
| 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><i>White</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                            |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12+</i> College (1-4 or 5+) <i></i>                                                                                                                                                       |  |                                                                                                                                                                                |                                                                                                       |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Teacher</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                            |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Education</i>                                                                                                                                                                                                                                             |  |                                                                                                                                                                                |                                                                                                       |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Olus Challen Williams</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Mary Alice Wishard</i>                                                                                                                                                                                                                 |  |                                                                                                                                                                                |                                                                                                       |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Stacey Sickels</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>209 SevernRiverRd, SevernaPark, MD21145</i>                                                                                                                                                |  |                                                                                                                                                                                |                                                                                                       |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                              |  |                                                                            |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)                                                                                                                                                                                                                |  | 20c. LOCATION — City or Town, State                                                                                                                                            |                                                                                                       |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSE<br><i>Ronald Wade, Dir</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br><i>State Anatomy board<br/>655W. Baltimore St, Balto, MD21201</i>                                                                                                                                                                                          |  |                                                                                                                                                                                |                                                                                                       |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Parkinson's Disease</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                | Approximate Interval Between Onset and Death                                                          |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>DCIT ② Dementia ③ Hip Fracture ④ Hip</i>                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |                                                                                                       |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                |                                                                                                       |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                      |  |                                                                            |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><i>M</i>                                                                                                                                                |                                                                                                       |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                            |  | 28d. DESCRIBE NOW INJURY OCCURRED                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                |                                                                                                       |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                            |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                   |  |                                                                                                                                                                                |                                                                                                       |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                       |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |                                                                                                       |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>William M.D.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                            |  | 29c. LICENSE NUMBER<br><i>D21313</i>                                                                                                                                                                                                                                                           |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>11/11/94</i>                                                                                                                         |                                                                                                       |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>KIN K WUN, 216 High St, Chestertown, Md 21620</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                            |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |                                                                                                       |
| 31. DATE FILED (Month, Day, Year)<br><i>NOV 18 1994</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                            |  | 32. REGISTRAR'S SIGNATURE<br><i>John Andrew Rodell</i>                                                                                                                                                                                                                                         |  |                                                                                                                                                                                |                                                                                                       |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION





94 33966

Item# 1.G-film 717 per F.H 11/18/94 P.C

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                      |                                                  |                                                                                                                                                                                                 |                                            |                                                                                                                                         |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><u>Roxie G. Yarish</u> Roxie Gae Yarish                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                      |                                                  | 2. DATE OF DEATH<br>MONTH <u>November</u> DAY <u>16</u> YEAR <u>1994</u>                                                                                                                        |                                            | 3. TIME OF DEATH<br><u>9:50 p</u> M                                                                                                     |  |
| 4. SOCIAL SECURITY NUMBER<br><u>220-22-3625</u>                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                           | 6. AGE (In yrs. last birthday)<br><u>77</u> YRS. | IF UNDER 1 YEAR<br>MONTHS _____ DAYS _____                                                                                                                                                      | IF UNDER 24 HRS.<br>HOURS _____ MIN. _____ | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><u>March 03, 1917</u>                                                                         |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><u>West Virginia</u>                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                      |                                                  | 9a. FACILITY NAME (If not institution, give street and number)<br><u>Union Memorial Hospital</u>                                                                                                |                                            | 9b. CITY, TOWN OR LOCATION OF DEATH<br><u>Baltimore City</u>                                                                            |  |
| 9c. COUNTY OF DEATH<br>---                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                      |                                                  | 10a. STATE<br><u>Maryland</u>                                                                                                                                                                   |                                            | 10b. COUNTY<br>---                                                                                                                      |  |
| 10c. CITY, TOWN OR LOCATION<br><u>Baltimore</u>                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                      |                                                  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                 |                                            |                                                                                                                                         |  |
| 10e. STREET AND NUMBER<br><u>1024 Union Avenue</u>                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                      |                                                  | 10f. ZIP CODE<br><u>21211</u>                                                                                                                                                                   |                                            | 10g. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                                                                                             |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                               |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                         |                                                  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |                                            | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><u>White</u>                                                              |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>8</u> College (1-4 or 5+) _____                                                                                                                                                                                                                                                                                         |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><u>Waitress</u>                                                                                                                                                                     |                                                  | 16b. KIND OF BUSINESS/INDUSTRY<br><u>Restaurant/Food Industry</u>                                                                                                                               |                                            |                                                                                                                                         |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><u>Rex Unknown Atkins</u>                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                      |                                                  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><u>Martha Rogers Holcomb</u>                                                                                                               |                                            |                                                                                                                                         |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><u>Sharon Gatha McCall</u>                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                      |                                                  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>1024 Union Avenue Baltimore, MD 21211</u>                                                   |                                            |                                                                                                                                         |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____                                                                                                                                                                                  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><u>Metro Crematory, Inc. 11/18</u>                                                                                                                                                                                |                                                  | 20c. LOCATION — City or Town, State<br><u>Baltimore, MD</u>                                                                                                                                     |                                            |                                                                                                                                         |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><u>George E. MacNabb</u>                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                      |                                                  | 22. NAME AND ADDRESS OF FACILITY<br><u>Cremation Society of Md., Inc.<br/>299 Frederick Rd. Balto., MD 21228</u>                                                                                |                                            |                                                                                                                                         |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                      |                                                  |                                                                                                                                                                                                 |                                            |                                                                                                                                         |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →                                                                                                                                                                                                                                                                                                                                                            |  | a. <u>Chronic Obstructive Pulmonary Disease</u>                                                                                                                                                                                                                                                      |                                                  |                                                                                                                                                                                                 |                                            | Approximate interval between Onset and Death<br><u>&gt; 5 years</u>                                                                     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              |  | b. <u>Asthma</u>                                                                                                                                                                                                                                                                                     |                                                  |                                                                                                                                                                                                 |                                            | <u>&gt; 5 years</u>                                                                                                                     |  |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                      |  | c. _____                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                                 |                                            |                                                                                                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              |  | d. _____                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                                 |                                            |                                                                                                                                         |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Hypertension</u><br><u>Diabetes</u>                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                      |                                                  |                                                                                                                                                                                                 |                                            |                                                                                                                                         |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____ |                                                  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                           |                                            | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined                                                                                                                                                   |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                               |                                                  | 28b. TIME OF INJURY<br>M _____                                                                                                                                                                  |                                            | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                    |                                                  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                          |                                            | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                            |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                                      |                                                  |                                                                                                                                                                                                 |                                            |                                                                                                                                         |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><u>Ellen Mahon, D.O.</u>                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                      |                                                  | 29c. LICENSE NUMBER<br><u>AT243 8946</u>                                                                                                                                                        |                                            | 29d. DATE SIGNED (Month, Day, Year)<br><u>November 16, 1994</u>                                                                         |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><u>Union Memorial Hospital, Baltimore, Md. 21218</u>                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                      |                                                  |                                                                                                                                                                                                 |                                            |                                                                                                                                         |  |
| 31. DATE FILED (Month, Day, Year)<br><u>NOV 18 1994</u>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                      |                                                  | 32. REGISTRAR'S SIGNATURE<br><u>J. H. ...</u>                                                                                                                                                   |                                            |                                                                                                                                         |  |

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                 |  |                                                                                                                                                              |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Peter J. Arapis</b>                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                               |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 12 1994 22:35 M</b>                                                                                                                           |  | 3. TIME OF DEATH PM                                                                                                                                          |  |
| 4. SOCIAL SECURITY NUMBER<br><b>051-16-7627</b>                                                                                                                                                                                                                                                                                                                                                                                      |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                    |  | 6. AGE (In yrs. last birthday)<br><b>75</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>January 2 1919</b>                                                                                                 |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>New York</b>                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                               |  | 9. COUNTY OF DEATH<br><b>AA County</b>                                                                                                                                                          |  |                                                                                                                                                              |  |
| 10. FACILITY NAME (If not institution, give street and number)<br><b>North Arundel Hospital</b>                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                               |  | 11. CITY, TOWN OR LOCATION OF DEATH<br><b>Glen Burnie</b>                                                                                                                                       |  |                                                                                                                                                              |  |
| 12. RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                               |  | 13. COUNTY OF DEATH                                                                                                                                                                             |  |                                                                                                                                                              |  |
| 14a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                        |  | 14b. COUNTY<br><b>Anne Arundel</b>                                                                                                                                                                                                                                                            |  | 14c. CITY, TOWN OR LOCATION<br><b>Odenton</b>                                                                                                                                                   |  | 14d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                              |  |
| 15. STREET AND NUMBER<br><b>604 Rolling Hill Walk</b><br><del>604 Rolling Hill Walk</del>                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                               |  | 16. ZIP CODE<br><b>21113</b>                                                                                                                                                                    |  | 17. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                                                                                                         |  |
| 18. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                       |  | 19. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                  |  | 20. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 21. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                      |  |
| 22. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>                                                                                                                                                                                                                                                                                              |  | 23. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Marketing/Sales</b>                                                                                                                                                        |  | 24. KIND OF BUSINESS/INDUSTRY<br><b>Pharmaceutical</b>                                                                                                                                          |  |                                                                                                                                                              |  |
| 25. FATHER'S NAME (First, Middle, Last)<br><b>John Peter Arapis</b>                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                               |  | 26. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Sophie (NMN) Dubrinski</b>                                                                                                              |  |                                                                                                                                                              |  |
| 27. INFORMANT'S NAME (Type/Print)<br><b>Susan Bright</b>                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                               |  | 28. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1743 Thistle Court Gambrills, Maryland 21054</b>                                             |  |                                                                                                                                                              |  |
| 29. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                 |  | 30. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Dulaney Valley Memorial Gar. 11/17/94</b>                                                                                                                                                                |  | 31. LOCATION — City or Town, State<br><b>Timonium, Maryland</b>                                                                                                                                 |  | 32. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                |  |
| 33. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Acute Anterior-lateral Myocardial Infarction</b><br>DUE TO (OR AS A CONSEQUENCE OF):                                                            |  | 34. SEQUENTIALLY list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>b. Ischemic Cardiomyopathy</b><br>DUE TO (OR AS A CONSEQUENCE OF):                                                       |  | 35. APPROXIMATE Interval Between Onset and Death<br><b>3 hours</b>                                                                                                                              |  | 36. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Ischemic Cardiomyopathy</b> |  |
| 37. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                         |  | 38. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                          |  | 39. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                          |  | 40. 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                        |  |
| 41. 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                                      |  | 42. 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  | 43. 28a. DATE OF INJURY (Month, Day, Year)<br><b>11/13/94</b>                                                                                                                                   |  | 44. 28b. TIME OF INJURY<br><b>M</b>                                                                                                                          |  |
| 45. 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                      |  | 46. 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                         |  | 47. 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                      |  | 48. 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                             |  |
| 49. 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 50. 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                                                                                                                                                                                                                                                 |  | 51. 29c. LICENSE NUMBER<br><b>DZ8000</b>                                                                                                                                                        |  | 52. 29d. DATE SIGNED (Month, Day, Year)<br><b>11/13/94</b>                                                                                                   |  |
| 53. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Marc Okun M.D., 203 Hospital Drive #206, Glen Burnie, MD. 21061</b>                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                 |  |                                                                                                                                                              |  |
| 54. 31. DATE FILED (Month, Day, Year)<br><b>NOV 21 1994</b>                                                                                                                                                                                                                                                                                                                                                                          |  | 55. 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                                                                              |  |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                   |  |                                                                                                 |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><del>ELIZABETH</del> Malinda Elizabeth Allen                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  | 2. DATE OF DEATH<br>MONTH 11 DAY 18 YEAR 1994                                                                                                                                                     |  | 3. TIME OF DEATH<br>11:45 PM                                                                    |  |
| 4. SOCIAL SECURITY NUMBER<br>219-03-2756                                                                                                                                                                                                                                                                                                                                                                                         |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                             |  | 8. AGE (In yrs. last birthday)<br>99 81 YRS.                                                                                                                                                      |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>JUL 27, 1913                                          |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>BAYVIEW HOSPITAL                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                            |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE CITY                                                                                                                                             |  | 9c. COUNTY OF DEATH<br>B/a                                                                      |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                   |  |                                                                                                 |  |
| 10a. STATE<br>MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                           |  | 10b. COUNTY<br>n/a                                                                                                                                                                                                                                                                                         |  | 10c. CITY, TOWN OR LOCATION<br>BALTIMORE                                                                                                                                                          |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>1032 N. C ASTLE STREET                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |  | 10f. ZIP CODE<br>21205                                                                                                                                                                            |  | 10g. CITIZEN OF WHAT COUNTRY?<br>UNITED STATES                                                  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                           |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                        |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>BLACK                             |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) no school                                                                                                                                                                                                                                                                                                                      |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>laborer                                                                                                                                                                                   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>TOMATO -CANNARY COMPANY                                                                                                                                         |  |                                                                                                 |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>PET ALEXANDER                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>MAGGIE MC PHERSON                                                                                                                            |  |                                                                                                 |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>ROBERT HURTT                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1032 N. CASTLE STREET, BALTIMORE, MD 21205                                                       |  |                                                                                                 |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of)<br>KING Memorial Park 11-22                                                                                                                                                                                                                                   |  | 20c. LOCATION — City or Town, State<br>RANDALLSTOWN, MD                                                                                                                                           |  |                                                                                                 |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Lee V. Holland                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br>WM. C. MARCH FH.-1101 E. NORTH AVENUE                                                                                                                         |  |                                                                                                 |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                   |  |                                                                                                 |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                   |  |                                                                                                 |  |
| a. CARDIAC ARRHYTHMIA AND ASYSTOLE<br>DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                   |  |                                                                                                 |  |
| b. ATRIAL FIBRILLATION<br>DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                   |  |                                                                                                 |  |
| c. ENLARGED LEFT ATRIUM<br>DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                   |  |                                                                                                 |  |
| d.                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                   |  |                                                                                                 |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                   |  |                                                                                                 |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>PLEURAL EFFUSION, PERICARDIAL EFFUSION, ANEMIA,<br>MALNUTRITION, S/P VAGOTOMY AND PYLOROPLASTY FOR PERFORATED ULCER<br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                   |  |                                                                                                 |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                   |  |                                                                                                 |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                        |  | 28a. DATE OF INJURY<br>(Month, Day, Year)                                                                                                                                                                                                                                                                  |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                          |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO            |  |
| 28d. DESCRIBE NOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                      |  |                                                                                                 |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                   |  |                                                                                                 |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>David Kaufmann, MD                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  | 29c. LICENSE NUMBER<br>JH Bayview ID #95080                                                                                                                                                       |  | 29d. DATE SIGNED (Month, Day, Year)<br>11/18/94                                                 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>DAVID KAUFMANN, MD - MEDICAL CENTER, 4940 EASTERN AVE. BALTO, MD 21224                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                   |  |                                                                                                 |  |
| 31. DATE FILED (Month, Day, Year)<br>NOV 21 1994                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson Randall                                                                                                                                               |  |                                                                                                 |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                                                       |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>JOHN E. BELL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                             |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>NOV 19 94                                                                                                                                                 |  | 3. TIME OF DEATH<br>4:18 P.                                                                 |                                                                                                       |
| 4. SOCIAL SECURITY NUMBER<br>214-07-8731                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                  |  | 6. AGE (In yrs. last birthday)<br>78 YRS.                                                                                                                                                       |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>MAR. 23, 1916                                     |                                                                                                       |
| 8. BIRTHPLACE (State or Foreign Country)<br>VIRGINIA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                             |  | 9a. FACILITY NAME (If not institution, give street and number)<br>BON SECOUR HOSPITAL                                                                                                           |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE CITY                                       |                                                                                                       |
| 9c. COUNTY OF DEATH<br>n/a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                             |  | 10a. STATE<br>MARYLAND                                                                                                                                                                          |  |                                                                                             |                                                                                                       |
| 10b. COUNTY<br>n/a                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 10c. CITY, TOWN OR LOCATION<br>BALTIMORE                                                                                                                                                                                                                                                    |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                 |  |                                                                                             |                                                                                                       |
| 10e. STREET AND NUMBER<br>102 N. BENTALOU STREET                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  | 10f. ZIP CODE<br>21223                                                                                                                                                                          |  | 10g. CITIZEN OF WHAT COUNTRY?<br>UNITED STATES                                              |                                                                                                       |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                             |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: BLACK                            |                                                                                                       |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 11 TH College (1-4 or 5+) -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                             |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>WELDER                                                                         |  | 16b. KIND OF BUSINESS/INDUSTRY<br>BETHLEHEM STEEL SHIPYARD                                  |                                                                                                       |
| 17. FATHER'S NAME (First, Middle, Last)<br>JAMES BELL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>AMANDA JARVIS                                                                                                                              |  |                                                                                             |                                                                                                       |
| 19a. INFORMANT'S NAME (Type/Print)<br>YOLANDA A. YOUNG                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                             |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>102 N. BENTALOU STREET, BALTIMORE, MD 21223                                                    |  |                                                                                             |                                                                                                       |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                              |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>WOODLAWN CEMETERY                                                                                                                                                                                        |  | DATE<br>11-22                                                                                                                                                                                   |  | 20c. LOCATION — City or Town, State<br>BALTIMORE, MARYLAND                                  |                                                                                                       |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Lee V. Holland</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                             |  | 22. NAME AND ADDRESS OF FACILITY<br>WM. C. MARCH FH.-1101 E. NORTH AVENUE                                                                                                                       |  |                                                                                             |                                                                                                       |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Atherosclerotic cardiovascular disease</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                             | Approximate Interval Between Onset and Death                                                          |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                             | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                                                       |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                                                       |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                                                       |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                          |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                      |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                        |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |                                                                                                       |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                             |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                          |  |                                                                                             |                                                                                                       |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                                                       |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                                                       |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                             |  | 29c. LICENSE NUMBER<br>O.C.M.E.                                                                                                                                                                 |  | 29d. DATE SIGNED (Month, Day, Year)<br>NOV 20, 1994                                         |                                                                                                       |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>David R Fowler 111 Penn Street, Baltimore, Maryland 21201                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                                                       |
| 31. DATE FILED (Month, Day, Year)<br>NOV 21 1994                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                                                                                                 |  |                                                                                             |                                                                                                       |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





94 33970

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                 |  |                                                                                                                                                     |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>John Bond John Henry Bond Jr.</i>                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 2. DATE OF DEATH<br>MONTH <i>11</i> DAY <i>18</i> YEAR <i>94</i>                                                                                                                                |  | 3. TIME OF DEATH<br><i>8:15p</i> M                                                                                                                  |  |
| 4. SOCIAL SECURITY NUMBER<br><i>218 12 4332</i>                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 6. AGE (In yrs. last birthday)<br><i>73</i> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><i>08 23 21</i>                                                                                              |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>Hopkins Bay View Medical Center</i>                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Baltimore City</i>                                                                                                                                    |  | 9c. COUNTY OF DEATH<br><i>Md.</i>                                                                                                                   |  |
| 10a. STATE<br><i>Md.</i>                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 10b. COUNTY<br><i>Baltimore</i>                                                                                                                                                                 |  | 10c. CITY, TOWN OR LOCATION<br><i>Colgate</i>                                                                                                       |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 10e. STREET AND NUMBER<br><i>7822 Eastdale Road</i>                                                                                                                                             |  |                                                                                                                                                     |  |
| 10f. ZIP CODE<br><i>21224</i>                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>                                                                                                                                                     |  |                                                                                                                                                     |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                               |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><i>WW 2</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><i>White</i>                                                                          |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>11</i> College (1-4 or 5+) <i></i>                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><i>T.V. Repair</i>                                                                 |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Self</i>                                                                                                       |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>John Henry Bond Sr.</i>                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Marie Wachter</i>                                                                                                                       |  |                                                                                                                                                     |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Jacqueline V. Bond</i>                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>7822 Eastdale Rd. Balto., Md. 21224</i>                                                     |  |                                                                                                                                                     |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Oak Lawn Cemetery 11-23-94</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 20c. LOCATION — City or Town, State<br><i>Eastwood, Md.</i>                                                                                                                                     |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Charles S. Zeiler</i>                                                                               |  |
| 22. NAME AND ADDRESS OF FACILITY<br><i>Charles S. Zeiler &amp; Son Inc.<br/>6224 Eastern Ave. Balto., Md.</i>                                                                                                                                                                                                                                                                                                                |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Myocardial Infarction</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><i>Congestive Heart Failure</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><i>Renal Failure</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                 |  |                                                                                                                                                     |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                 |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                               |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                 |  | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/> |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                 |  |                                                                                                                                                     |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide                                                                                                                                                |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                        |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                         |  |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                       |  | 28e. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                 |  |                                                                                                                                                     |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>M. Halaby Holmes MD</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 29c. LICENSE NUMBER<br><i>94004</i>                                                                                                                                                             |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>11/18/94</i>                                                                                              |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Type, Print)<br><i>Michelle Halaby Holmes - John's Hopkins Bayview Medical Center</i>                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                 |  |                                                                                                                                                     |  |
| 31. DATE FILED (Month, Day, Year)<br><i>NOV 21 1994</i>                                                                                                                                                                                                                                                                                                                                                                      |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson Randall</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                     |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE REGISTRAR OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33971

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ADDIE LOUISE BUNDY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                |  | 2. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>18</b> YEAR <b>94</b>                                                                                                                                                                                                                                           |  | 3. TIME OF DEATH<br><b>6A</b> M                                                                                                                                                        |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-22-7479</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>77</b> YRS.                                                                                                                                                                                                                                                           |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>March 12, 17</b>                                                                                                                             |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>VA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>14 Walden Poplar ct</b>                                                                                                                                                                                                               |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Balto</b>                                                                                                                                    |  |
| 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                |  | 10a. STATE<br><b>md</b>                                                                                                                                                                                                                                                                                    |  | 10b. COUNTY                                                                                                                                                                            |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Balto</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                        |  | 10e. STREET AND NUMBER<br><b>14 Walden Poplar ct.</b>                                                                                                                                  |  |
| 10f. ZIP CODE<br><b>21207</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                             |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                                                                                                        |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                                                                                                                |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (9-12) <b>6th</b> College (1-4 or 5+) <b></b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Domestic</b>                                                                                                                                                                              |  | 16b. KIND OF BUSINESS/INDUSTRY                                                                                                                                                         |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>James Beane</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Nannie Bundy</b>                                                                                                                                                                                                                                   |  |                                                                                                                                                                                        |  |
| 19a. INFORMANT'S NAME (Type, Print)<br><b>Elsie Madden</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>14 madden poplar ct Balto, md 21207</b>                                                                                                                                                                |  |                                                                                                                                                                                        |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>mt. Calvary Cemetery 11/24/94</b>                                                                                                                                                                                    |  | 20c. LOCATION — City or Town, State<br><b>Anne Arundel Co, md</b>                                                                                                                      |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Sala March</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>March F.H. - West 4300 warbash Ave</b>                                                                                                                                                                                                                              |  |                                                                                                                                                                                        |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                   |  |                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                        |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                            |  |                                                                                |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                     |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                        |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                |  | 28d. DESCRIBE NOW INJURY OCCURRED                                                                                                                                                                                                                                                                          |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                 |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                     |  |                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>E. P. Williams M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                |  | 29c. LICENSE NUMBER<br><b>D11171</b>                                                                                                                                                                                                                                                                       |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/18/94</b>                                                                                                                                 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>E. P. Williams M.D. - 405 Frederick Ave - CATONSVILLE 21228 md</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                        |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 21 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                |  | 32. REGISTRAR'S SIGNATURE<br><b>2128 md</b>                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                        |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33972

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                               |  |                                                                         |                                                                                                                                         |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>BERNARD L. BRANNOCK</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                      |  | 2. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>19</b> YEAR <b>94</b>                                                                                                                                                                                                              |  | 3. TIME OF DEATH<br><b>8:35 P M</b>                                     |                                                                                                                                         |
| 4. SOCIAL SECURITY NUMBER<br><b>220 14 5700</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                           |  | 6. AGE (In yrs. last birthday)<br><b>67</b> YRS.                                                                                                                                                                                                                              |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>8/4/27</b>                 |                                                                                                                                         |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>University of Maryland Hospital Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                      |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                       |  | 9c. COUNTY OF DEATH<br><b>MD</b>                                        |                                                                                                                                         |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                      |  | 10b. COUNTY<br><b>Baltimore</b>                                                                                                                                                                                                                                               |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                         |                                                                                                                                         |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                      |  | 10e. STREET AND NUMBER<br><b>3715 E. Pratt Street</b>                                                                                                                                                                                                                         |  |                                                                         |                                                                                                                                         |
| 10f. ZIP CODE<br><b>21224</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                      |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                                                                |  |                                                                         |                                                                                                                                         |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>Korean War</b> |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                               |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b> |                                                                                                                                         |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b><br>College (1-4 or 5+) <b>----</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Bricklayer/Inspector</b>                         |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>City of Baltimore</b>                                                                                                                                                                                                                    |  |                                                                         |                                                                                                                                         |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Carlton Brannock</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                      |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ella Megary</b>                                                                                                                                                                                                       |  |                                                                         |                                                                                                                                         |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Anna T. Brannock</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                      |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3715 E. Pratt Street Balto. Md. 21224</b>                                                                                                                                 |  |                                                                         |                                                                                                                                         |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                    |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Moreland Mem. Park</b>                                                         |  | 20c. LOCATION — City or Town, State<br><b>11-24 Baltimore, Maryland</b>                                                                                                                                                                                                       |  | 20d. DATE<br><b>11-24</b>                                               |                                                                                                                                         |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Carl Brannock</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                      |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Joseph N. Zannino Jr. Funeral Home<br/>263 S. Conkling St. Balto. Md. 21224</b>                                                                                                                                                        |  |                                                                         |                                                                                                                                         |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>SEPSIS</b><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. <b>LUNG CANCER.</b><br>c.<br>d.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF): |  |                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                               |  |                                                                         | Approximate interval Between Onset and Death                                                                                            |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>HEART DISEASE</b><br><b>DIABETES MELLITUS</b><br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                               |  |                                                                         | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                               |  |                                                                         | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                      |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Nomicide <input type="checkbox"/> Could not be determined |  |                                                                         |                                                                                                                                         |
| 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                      |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                              |  | 28d. DESCRIBE NOW INJURY OCCURRED                                       |                                                                                                                                         |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                      |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                  |  |                                                                         |                                                                                                                                         |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                             |  |                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                               |  |                                                                         |                                                                                                                                         |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>BAlexander MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                      |  | 29c. LICENSE NUMBER<br><b>U40002</b>                                                                                                                                                                                                                                          |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/19/94</b>                  |                                                                                                                                         |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>BARBARA ALEXANDER, UNIV. OF MD MEDICAL SYSTEM 225 GREEN ST.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                               |  |                                                                         |                                                                                                                                         |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 21 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                      |  | 31. REGISTRAR'S SIGNATURE<br><i>Julia [Signature]</i>                                                                                                                                                                                                                         |  |                                                                         |                                                                                                                                         |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

University of California, Berkeley

John Doe

1234

1234

3712

1234

1234

1234

1234

1234

1234

3712

1234

11-24

1234

914 33973

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                            |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Laurence E. Butler</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                            |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov 19 - 1994</b>                                                                                                                                                                                                                          |  | 3. TIME OF DEATH<br><b>9:18 A M</b>                                                                                                                                            |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-34-4069</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>59</b> YRS.                                                                                                                                                                                                                                    |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>04-04-1935</b>                                                                                                                    |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                            |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Mercy Medical Center</b>                                                                                                                                                                                       |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>                                                                                                                        |  |
| 9c. COUNTY OF DEATH<br><b>—</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                            |  | 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                       |  | 10b. COUNTY<br><b>—</b>                                                                                                                                                        |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                            |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                     |  | 10e. STREET AND NUMBER<br><b>3220 Mc Elderry Street</b>                                                                                                                        |  |
| 10f. ZIP CODE<br><b>21205</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                            |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                                                                      |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                            |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                     |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                        |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (14 or 5+) <b>—</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                            |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Mechanic - Guard</b>                                                                                                                                            |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Wells Fargo</b><br><b>Carr-Lowery Glass Corp.</b>                                                                                         |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Francis J. Butler</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Anna Rachel Matthews</b>                                                                                                                                                                                                    |  |                                                                                                                                                                                |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Victoria J. Butler</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3220 Mc Elderry St. Balto Md 21205</b>                                                                                                                                          |  |                                                                                                                                                                                |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                            |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Greenmount Cemetery 11-21 Baltimore, Md</b>                                                                                                                                                   |  | 20c. LOCATION — City or Town, State                                                                                                                                            |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Charles Zannino</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Joseph N. Zannino Jr. Funeral Home</b><br><b>263 S. Conkling St. Balto. Md. 21224</b>                                                                                                                                                        |  |                                                                                                                                                                                |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Respiratory Failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>a. <b>Metastatic Lung Cancer</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |                                                                            |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                |  |
| Approximate Interval Between Onset and Death<br><b>months</b><br><b>years</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                            |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>                                                                                                                                                                                                                                                                                                                                                           |  |                                                                            |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                       |  |                                                                            |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                              |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                            |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                            |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                        |  |                                                                                                                                                                                |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                        |  |                                                                            |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Dwaine Bobo, MD Resident.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                            |  | 29c. LICENSE NUMBER<br><b>P08176</b>                                                                                                                                                                                                                                                |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/19/94</b>                                                                                                                         |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dwaine Bobo M.D. 301 St. Paul Place Balto. Md. 21202</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                            |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 21 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                            |  | 32. REGISTRAR'S SIGNATURE<br><b>John Andrew Randall</b>                                                                                                                                                                                                                             |  |                                                                                                                                                                                |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

[illegible]



94 33974

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                                                                    |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>RAYMOND L. BROWN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                             |  | 2. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>13</b> YEAR <b>94</b>                                                                                                                                |  | 3. TIME OF DEATH<br><b>9.05 PM</b>                                                                                                                 |  |
| 4. SOCIAL SECURITY NUMBER<br><b>418-12-6795</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                  |  | 6. AGE (In yrs. last birthday)<br><b>74</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>11 9 20 Alabama</b>                                                                                      |  |
| 8. FACILITY NAME (If not institution, give street and number)<br><b>Deaton Spec. Hosp &amp; Home</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                             |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>                                                                                                                                         |  | 9c. COUNTY OF DEATH                                                                                                                                |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                                                                    |  |
| 10a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 10b. COUNTY                                                                                                                                                                                                                                                                                 |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>                                                                                                                                                 |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                    |  |
| 10e. STREET AND NUMBER<br><b>833 W. Pratt St. Apt. 708</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  | 10f. ZIP CODE<br><b>21201</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                        |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>1940's</b>                                                                                                                               |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                                                                            |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>LABORER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>LABORER</b>                                                                                                                                                                |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>CONSTRUCTION</b>                                                                                                                                           |  |                                                                                                                                                    |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Sam Brown</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                             |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Minnie Burns-Brown</b>                                                                                                                  |  |                                                                                                                                                    |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>VERA / CHANEY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>19585 A BAYVIEW ST. CITRONELLE ALA 36522</b>                                                |  |                                                                                                                                                    |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, funeral home, or other place)<br><b>MT. ZION CH. 11/24/94 LANSDOWNE MD.</b>                                                                                                                                                           |  | 20c. DATE<br><b>11/24/94</b>                                                                                                                                                                    |  | 20d. LOCATION — City or Town, State<br><b>LANSDOWNE MD.</b>                                                                                        |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>[Signature]</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                             |  | 22. NAME AND ADDRESS OF FAMILY<br><b>GARY P. BROWN / 170 FREDERICK PASS BALT. MD. 21229</b>                                                                                                     |  |                                                                                                                                                    |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CHRONIC OBSTRUCTIVE PULM. DISEASE</b><br><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br><b>CORONARY HEART DISEASE</b><br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br><br>d. |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                                                                    |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                              |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                                                                    |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                 |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                      |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                   |  |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                             |  | 28e. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                               |  |                                                                                                                                                    |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                            |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>[Signature] MD</b>                                                                                                                                                                                                                              |  | 29c. LICENSE NUMBER<br><b>245045</b>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/13/94</b>                                                                                             |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DEATON HOSP &amp; MED CENTER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                                                                    |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 21 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 32. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                                                                    |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33975

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                           |  |                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Claire W. Bauer</b>                                                                                                                                                                                                                        |  |                                                                            |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov. 18, 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 3. TIME OF DEATH<br><b>11:10 P M</b>                                                                                                                                           |  |
| 4. SOCIAL SECURITY NUMBER<br><b>233-32-9688</b>                                                                                                                                                                                                                                           |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>79</b> YRS.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>April 10 1915</b>                                                                                                                    |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>West Virginia</b>                                                                                                                                                                                                                          |  |                                                                            |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>1420 Virginia Ave.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Severn</b>                                                                                                                           |  |
| 9c. COUNTY OF DEATH<br><b>Anne Arundel</b>                                                                                                                                                                                                                                                |  |                                                                            |  | 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 10b. COUNTY<br><b>Anne Arundel</b>                                                                                                                                             |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Severn</b>                                                                                                                                                                                                                                              |  |                                                                            |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 10e. STREET AND NUMBER<br><b>1420 Virginia Ave.</b>                                                                                                                            |  |
| 10f. ZIP CODE<br><b>21144</b>                                                                                                                                                                                                                                                             |  |                                                                            |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                              |  |                                                                            |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Year or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                                                                                                                   |  |                                                                            |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>Clerical</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Clerical</b>                                                                                                                                                             |  |                                                                            |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Social Security Administration</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Albert D. Wiley</b>                                                                                                                                                                                                                         |  |                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Grace Sturdivant</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Carolyn Heilker</b>                                                                                                                                                                                                                              |  |                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1420 Virginia Ave. Severn, Md. 21144</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                     |  |                                                                            |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place)<br><b>Meadowridge Cemetery 11/22/94</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                |  |
| 20c. LOCATION — City or Town, State<br><b>Howard Co., Maryland</b>                                                                                                                                                                                                                        |  |                                                                            |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>Stallings Funeral Home PA<br/>3111 Mountain Rd. Pasadena, Md. 21122</b>                                                                                                                                                                            |  |                                                                            |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Multiple Cerebral Infarctions</b><br>DUE TO (OR AS A CONSEQUENCE OF): <b>b. Insulin Dependent Diabetes Mellitus</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><b>Hyper tension</b> |  |                                                                                                                                                                                |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                     |  |                                                                            |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                  |  |                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                         |  |                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined |  |                                                                            |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>Nov. 18, 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                |  |
| 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                                                                                                           |  |                                                                            |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                         |  |                                                                            |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                              |  |                                                                            |  | 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i> MD                                                                                                                                                                                                                            |  |                                                                            |  | 29c. LICENSE NUMBER<br><b>DO2519</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>11/21/94</b>                                                                                                                                                                                                                                    |  |                                                                            |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Richard E Fisher Crain Towers Glen Burnie 21061</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 21 1994</b>                                                                                                                                                                                                                                   |  |                                                                            |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33976

Item#19a Per F.H. Film# G-717 11/23/94 R.M.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                     |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>HAL V BRASWELL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                      |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov 17 94</b>                                                                                                                                                                                                                                                     |  | 3. TIME OF DEATH<br><b>6:12 a.m.</b>                                                                |  |
| 4. SOCIAL SECURITY NUMBER<br><b>238-12-5782</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                       |  | 6. AGE (In yrs. last birthday)<br><b>72</b> YRS.                                                                                                                                                                                                                                                           |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>7-20-1922</b>                                             |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Good Samaritan Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                      |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>                                                                                                                                                                                                                                                    |  | 9c. COUNTY OF DEATH<br><b>North Carolina</b>                                                        |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                     |  |
| 10a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 10b. COUNTY<br><b>Baltimore</b>                                                                                                                                      |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                                                                                                                                                                                                                                                            |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>7507 Park Dr.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                      |  | 10f. ZIP CODE<br><b>21234</b>                                                                                                                                                                                                                                                                              |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                      |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>W.W.II</b> |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                                                                                                        |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                             |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) _____ College (1-4 or 5+) _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                      |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Electrician</b>                                                                                                                                                                           |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Theatre</b>                                                    |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Howell Braswell</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                      |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Lillian Braswell</b>                                                                                                                                                                                                                               |  |                                                                                                     |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MRS. JEAN H. BRASWELL</b><br><b>Mrs. Joan H. Braswell</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                      |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7507 Park Dr. Balto., Md. 21234</b>                                                                                                                                                                    |  |                                                                                                     |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) _____                                                                                                                                                                                                                                                                                                                                                                                                         |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Greenmount Crematory 11/19 Balto., Md.</b>                                     |  | 20c. LOCATION — City or Town, State<br><b>Balto., Md.</b>                                                                                                                                                                                                                                                  |  | 20d. DATE<br><b>11/19</b>                                                                           |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Hartley Miller</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                      |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Hartley Miller Funeral Home<br/>7527 Hanford Rd. Balto., Md. 21234</b>                                                                                                                                                                                              |  |                                                                                                     |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Respiratory Arrest</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. Intracerebral Bleeding</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c. HYPERTENSION</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d.</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                     |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                     |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                      |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                     |  |                                                                                                     |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                      |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                     |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                     |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                               |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                                                                                                                            |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                      |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                     |  |                                                                                                     |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                      |  | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                               |  |                                                                                                     |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                              |  |                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                     |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Liza L. Jax, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                      |  | 29c. LICENSE NUMBER<br><b>PO 7640</b>                                                                                                                                                                                                                                                                      |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>Nov 17, 1994</b>                                          |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Muhammad Zaydan, MD, Good Samaritan Hospital, Baltimore, MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                     |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 21 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                     |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33977

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                                 |  |                                                                                                 |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>E. Louise Brock</b>                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |                                                  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov. 19, 1994</b>                                                                                                                                      |  | 3. TIME OF DEATH<br><b>12:10 P. M.</b>                                                          |  |
| 4. SOCIAL SECURITY NUMBER<br><b>287 07 1379</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                     | 6. AGE (In yrs. last birthday)<br><b>83</b> YRS. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Feb. 5, 1911</b>                                                                                                                                   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Tenn.</b>                                        |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>3938 Sharp Road</b>                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |                                                  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Glenelg</b>                                                                                                                                           |  | 9c. COUNTY OF DEATH<br><b>Howard</b>                                                            |  |
| 10a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                     |  | 10b. COUNTY<br><b>Howard</b>                                                                                                                                                                                                                                                                   |                                                  | 10c. CITY, TOWN OR LOCATION<br><b>Glenelg</b>                                                                                                                                                   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>3938 Sharp Road</b>                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |                                                  | 10f. ZIP CODE<br><b>21737</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                               |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                   |                                                  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                      |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>High School</b><br>College (1-4 or 5+) <b>=</b>                                                                                                                                                                                                                                                                         |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Paper Tester</b>                                                                                                                                                           |                                                  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Swog Paper Co.</b>                                                                                                                                         |  |                                                                                                 |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Louis C. Berry</b>                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |                                                  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Sylvia Dykes</b>                                                                                                                        |  |                                                                                                 |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Marie Heath</b>                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |                                                  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3938 Sharp Road Glenelg, Md. 21737</b>                                                      |  |                                                                                                 |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>West Chester Cemetery Nov. 23, 1994</b>                                                                                                                                                                  |                                                  | 20c. LOCATION — City or Town, State<br><b>West Chester, Ohio</b>                                                                                                                                |  |                                                                                                 |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Harry W. Haight</b>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |                                                  | 22. NAME AND ADDRESS OF FACILITY<br><b>Haight Funeral Home<br/>P.O. Box 195 Sykesville, MD. 21784</b>                                                                                           |  |                                                                                                 |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>STROKE</b>                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| Due to (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| Due to (OR AS A CONSEQUENCE OF): <b>ARTERIO SCLEROTIC DISEASE</b>                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| Due to (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| Due to (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| Due to (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Pneumonia with Atrial Fibrillation</b>                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 24a. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |                                                  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                              |  |                                                                                                 |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide                                                                                                                                                |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |                                                  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                              |                                                  |                                                                                                                                                                                                 |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                   |                                                  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Eugene J. [Signature]</b>                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |                                                  | 29c. LICENSE NUMBER<br><b>025947</b>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/20/94</b>                                          |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Patricia Jackson, 5540 TEN OAKS RD CLARKSVILLE MD 21029</b>                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |                                                  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 1994</b>                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |                                                  | 32. REGISTRAR'S SIGNATURE<br><b>Julia [Signature]</b>                                                                                                                                           |  |                                                                                                 |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                 |  |                                                                                                                                                                                                 |  |                                                                                             |  |                                                                                                       |  |                                                                                                                                                    |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>RHEA D. COMPISI</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                 |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 18, 1994</b>                                                                                                                                  |  |                                                                                             |  | 3. TIME OF DEATH<br><b>M</b>                                                                          |  |                                                                                                                                                    |  |
| 4. SOCIAL SECURITY NUMBER<br><b>197-69-4384</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                      |  | 6. AGE (In yrs. last birthday)<br><b>82</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>MAY 24, 1912</b>                               |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>ITALY</b>                                              |  |                                                                                                                                                    |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>719 MAIDEN CHOICE LA-APT-124</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                 |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>catonsville</b>                                                                                                                                       |  |                                                                                             |  | 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>                                                               |  |                                                                                                                                                    |  |
| 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 10b. COUNTY<br><b>BALTIMORE</b>                                                                                                                 |  | 10c. CITY, TOWN OR LOCATION<br><b>CATONSVILLE</b>                                                                                                                                               |  |                                                                                             |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO       |  |                                                                                                                                                    |  |
| 10e. STREET AND NUMBER<br><b>719 MAIDEN CHOICE LA-APT-124-HERBERTS RUN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                 |  | 10f. ZIP CODE<br><b>21229</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                              |  |                                                                                                       |  |                                                                                                                                                    |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                     |  |                                                                                                       |  |                                                                                                                                                    |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (14 or 5+) <input checked="" type="checkbox"/> <b>1 YR - 1 YR.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>CLAIMS REPRESENTATIVE</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>SOCIAL SECURITY</b>                                                                                                                                        |  |                                                                                             |  |                                                                                                       |  |                                                                                                                                                    |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>NICHOLAS DiGIUSEPPE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                 |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>OLYMPIA (UNKNOWN)</b>                                                                                                                   |  |                                                                                             |  |                                                                                                       |  |                                                                                                                                                    |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>RICHARD COMPISI</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                 |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>511 COUNCIL COURT-VIENNA, VA. 21182</b>                                                     |  |                                                                                             |  |                                                                                                       |  |                                                                                                                                                    |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>DULANEY VALLEY MEMORIAL GA 11/21 cockeysville</b>         |  | 20c. LOCATION — City or Town, State                                                                                                                                                             |  |                                                                                             |  |                                                                                                       |  |                                                                                                                                                    |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                 |  | 22. NAME AND ADDRESS OF FACILITY<br><b>HUBBARD FUNERAL HOME, INC.<br/>4107 WILKENS AVENUE-BALTIMORE, MD 21229</b>                                                                               |  |                                                                                             |  |                                                                                                       |  |                                                                                                                                                    |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. ADENOCARCINOMA OF BREAST; COLON;</b> MONTHS<br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>b. AND AMPULLA OF VATER</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br><br>d. |  |                                                                                                                                                 |  |                                                                                                                                                                                                 |  |                                                                                             |  | Approximate Interval Between Onset and Death                                                          |  |                                                                                                                                                    |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                 |  |                                                                                                                                                                                                 |  |                                                                                             |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | HOSPITAL:<br><input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA                             |  | 26. PLACE OF DEATH (Check only one)<br>OTHER:<br><input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                              |  |                                                                                             |  |                                                                                                       |  |                                                                                                                                                    |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                                       |  | 28a. DATE OF INJURY<br>(Month, Day, Year)                                                                                                       |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                     |  |                                                                                                                                                    |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                 |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                    |  |                                                                                             |  |                                                                                                       |  |                                                                                                                                                    |  |
| 29a. CERTIFIER<br>(Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                     |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Matthew J. Nardetti</i>                                                                             |  | 29c. LICENSE NUMBER<br><b>D44748</b>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/18/94</b>                                      |  |                                                                                                       |  |                                                                                                                                                    |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MATTHEW J. NARDETT</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                 |  | 31. DATE FILED (Month, Day, Year)<br><b>NOV 21 1994</b>                                                                                                                                         |  |                                                                                             |  |                                                                                                       |  |                                                                                                                                                    |  |
| 32. REGISTRAR'S SIGNATURE<br><i>John Davidson Randall</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                 |  |                                                                                                                                                                                                 |  |                                                                                             |  |                                                                                                       |  |                                                                                                                                                    |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



B.K.S

94 33979

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                      |  |                                                                                                                                          |  |                                                                     |  |                                                         |  |                                                                                           |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|---------------------------------------------------------|--|-------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>KENNETH W. CLARY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                      |  |                                                                                                                                          |  | 2. DATE OF DEATH<br>MONTH NOV DAY 3 YEAR 94                         |  | 3. TIME OF DEATH<br>1945 P.M.                           |  |                                                                                           |  |
| 4. SOCIAL SECURITY NUMBER<br>212-66-7839                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 5. SEX<br>X M 2 F                                                                                                                    |  | 6. AGE (In yrs. last birthday)<br>37 YRS.                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Nov 4 1956                   |  | 8. BIRTHPLACE (State or Foreign Country)<br>Wash., D.C. |  |                                                                                           |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>NORTH ARUNDEL HOSPITAL E.R.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                      |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Glen Burnie                                                                                       |  |                                                                     |  | 9c. COUNTY OF DEATH<br>ANNE ARUNDEL                     |  |                                                                                           |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                      |  |                                                                                                                                          |  |                                                                     |  |                                                         |  |                                                                                           |  |
| 10a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 10b. COUNTY<br>Anne Arundel                                                                                                          |  | 10c. CITY, TOWN OR LOCATION<br>Crofton                                                                                                   |  |                                                                     |  | 10d. INSIDE CITY LIMITS?<br>XX YES 2 NO                 |  |                                                                                           |  |
| 10e. STREET AND NUMBER<br>1711 Greentree Ct.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                      |  | 10f. ZIP CODE<br>21114                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA                                |  |                                                         |  |                                                                                           |  |
| 11. MARITAL STATUS<br>1 Never Married 2 X Married<br>3 Widowed 4 Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO<br>IF YES, GIVE WAR OR DATES                                                  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 YES 2 X NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>Cauc. |  |                                                         |  |                                                                                           |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                      |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Process Server             |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Self-Employed                     |  |                                                         |  |                                                                                           |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Fred Clary                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                      |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Claudia Draughn                                                                     |  |                                                                     |  |                                                         |  |                                                                                           |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Regina B. Clary                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                      |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1711 Greentree Ct. Crofton, MD 21114    |  |                                                                     |  |                                                         |  |                                                                                           |  |
| 20a. METHOD OF DISPOSITION<br>1 Burial 2 Cremation 3 Removal from State<br>4 Donation 5 Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Fort Lincoln Cemetery 11/8                        |  |                                                                                                                                          |  | DATE                                                                |  | 20c. LOCATION — City or Town, State<br>Brentwood, MD    |  |                                                                                           |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                      |  | 22. NAME AND ADDRESS OF FACILITY<br>Rendon/Hale Funeral Home<br>9013 Annapolis Rd. Lanham, MD 20706                                      |  |                                                                     |  |                                                         |  |                                                                                           |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. Arteriosclerotic Cardiovascular Disease<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |                                                                                                                                      |  |                                                                                                                                          |  |                                                                     |  | Approximate Interval Between Onset and Death            |  |                                                                                           |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                      |  |                                                                                                                                          |  |                                                                     |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 X YES 2 NO          |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 YES 2 NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                      |  |                                                                                                                                          |  |                                                                     |  |                                                         |  |                                                                                           |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>XX YES 2 NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 Inpatient XX Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) |  |                                                                                                                                          |  |                                                                     |  |                                                         |  |                                                                                           |  |
| 27. MANNER OF DEATH<br>1 X Natural 5 Pending Investigation<br>2 Accident 6 Could not be determined<br>3 Suicide 4 Homicide                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                               |  | 28b. TIME OF INJURY M                                                                                                                    |  | 28c. INJURY AT WORK? 1 YES 2 NO                                     |  | 28d. DESCRIBE HOW INJURY OCCURRED                       |  |                                                                                           |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                      |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                             |  |                                                                     |  |                                                         |  |                                                                                           |  |
| 29a. CERTIFIER (Check only one)<br>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                           |  |                                                                                                                                      |  |                                                                                                                                          |  |                                                                     |  |                                                         |  |                                                                                           |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                      |  | 29c. LICENSE NUMBER<br>O.C.M.E                                                                                                           |  | 29d. DATE SIGNED (Month, Day, Year)<br>NOV. 4, 1994                 |  |                                                         |  |                                                                                           |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>THEODORE M. K... 111 Penn Street, Baltimore, Maryland 21201                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                      |  |                                                                                                                                          |  |                                                                     |  |                                                         |  |                                                                                           |  |
| 31. DATE FILED (Month, Day, Year)<br>NOV 9 1994                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                        |  |                                                                                                                                          |  |                                                                     |  |                                                         |  |                                                                                           |  |

DNMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760. BALTIMORE, MARYLAND 21215-0020

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within \_\_\_\_\_ hours after death. Page 6 may be retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be returned to you within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



94 33980

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                        |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Bernard I. Cook Sr.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                |  | 2. DATE OF DEATH<br>MONTH 11 DAY 02 YEAR 94                                                                                                                                                                                                                                                     |  | 3. TIME OF DEATH<br>M                                                                                                                                                                  |  |
| 4. SOCIAL SECURITY NUMBER<br>213-26-9292                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>62 YRS.                                                                                                                                                                                                                                                       |  | 7. DATE OF BIRTH (Month, Day, Year)<br>11 30 31                                                                                                                                        |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Liberty Medical Center                                                                                                                                                                                                        |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore                                                                                                                                       |  |
| 9c. COUNTY OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                |  | 10a. STATE<br>MD.                                                                                                                                                                                                                                                                               |  | 10b. COUNTY                                                                                                                                                                            |  |
| 10c. CITY, TOWN OR LOCATION<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                             |  | 10e. STREET AND NUMBER<br>2910 Presbury Street                                                                                                                                         |  |
| 10f. ZIP CODE<br>21216                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.                                                                                                                                                                                                                                                           |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                                                                                             |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: Black                                                                                                                       |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12th<br>College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Fork Lift Operator                                                                                                                                                                |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Transco                                                                                                                                              |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Taylor Cook                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Agnes Prott                                                                                                                                                                                                                                |  |                                                                                                                                                                                        |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Christine Francis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2910 Presbury Street Balto., MD. 21216                                                                                                                                                         |  |                                                                                                                                                                                        |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>MD. National Mem. PK. 11/94                                                                                                                                                                                  |  | 20c. LOCATION — City or Town, State<br>Laurel, MD.                                                                                                                                     |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Dorothea Hectr CFSP 281                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br>1721-27 N. Monroe ST. E.L. Phillips F/H Balto., MD. 21217                                                                                                                                                                                                   |  |                                                                                                                                                                                        |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiac arrest<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. Probable acute myocardial infarction<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. Coronary artery disease<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. Hypertensive arteriosclerotic cardiovascular disease<br>Approximate Interval Between Onset and Death<br>1 hr<br>1 hr<br>7 months<br>20 years |  |                                                                                |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                        |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Hypercholesterolemia                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                        |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                        |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                        |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                        |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                        |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                          |  | 28b. TIME OF INJURY<br>M                                                                                                                                                               |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                        |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                    |  |                                                                                                                                                                                        |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                         |  |                                                                                |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                        |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Patricia A. Jenkins MD MPH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                |  | 29c. LICENSE NUMBER<br>D18350                                                                                                                                                                                                                                                                   |  | 29d. DATE SIGNED (Month, Day, Year)<br>11-16-94                                                                                                                                        |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>PATRICIA A JENKINS, MD MPH 2300 Garrison Boulevard Suite 20<br>BALTIMORE, MARYLAND 21216                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                        |  |
| 31. DATE FILED (Month, Day, Year)<br>NOV 21 1994                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                |  | 32. REGISTRAR'S SIGNATURE<br>John Davidson Randall                                                                                                                                                                                                                                              |  |                                                                                                                                                                                        |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, the medical examiner must be notified at once.



6672-510

DWG

94 33981

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                         |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>THOMAS A. CARR</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                             |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOV. 17 94</b>                                                                                                                                         |  | 3. TIME OF DEATH<br><b>4:55P</b>                                                                |                                                                                                                         |
| 4. SOCIAL SECURITY NUMBER<br><b>219-38-2935</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                  |  | 6. AGE (In yrs. last birthday)<br><b>51</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>4/19/43</b>                                           |                                                                                                                         |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Liberty Medical Center</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                             |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>                                                                                                                                    |  | 9c. COUNTY OF DEATH<br><b>BALTO., MD</b>                                                        |                                                                                                                         |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                         |
| 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 10b. COUNTY                                                                                                                                                                                                                                                                                 |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>                                                                                                                                                 |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |                                                                                                                         |
| 10e. STREET AND NUMBER<br><b>3200 AUCHENTOROLY TERRACE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                             |  | 10f. ZIP CODE<br><b>21217</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                     |                                                                                                                         |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                             |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                         |                                                                                                                         |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b><br>College (1-4 or 5+) <b>College</b>                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Mover</b>                                                                                                                                                               |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Morten Movers</b>                                                                                                                                          |  |                                                                                                 |                                                                                                                         |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John W. Carr</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                             |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Elsie E. Dorsey</b>                                                                                                                     |  |                                                                                                 |                                                                                                                         |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Elizabeth Thomas</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2850 Garrison Avenue Balto., MD 21215</b>                                                   |  |                                                                                                 |                                                                                                                         |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                      |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>King Memorial Park 11/21</b>                                                                                                                                                                          |  | 20c. LOCATION — City or Town, State<br><b>Randallstown, MD</b>                                                                                                                                  |  |                                                                                                 |                                                                                                                         |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Leroy O. Dyett</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                             |  | 22. NAME AND ADDRESS OF FACILITY<br><b>LEROY O. DYETT &amp; SON FUNERAL HOME<br/>4600 LIBERTY HEIGHTS AVENUE 21207</b>                                                                          |  |                                                                                                 |                                                                                                                         |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Fatty Liver</i><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                 | Approximate Interval Between Onset and Death                                                                            |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                 | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br><i>limited</i> |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                         |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                         |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                         |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                              |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                      |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |                                                                                                                         |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)                                                                                                                                                                                                      |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                         |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                         |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                         |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Theodore M. King</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                             |  | 29c. LICENSE NUMBER<br><b>O.C.M.E.</b>                                                                                                                                                          |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>NOV. 18/94</b>                                        |                                                                                                                         |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                         |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 21 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                             |  | 32. REGISTRAR'S SIGNATURE<br><i>Jubel Davidson Randall</i>                                                                                                                                      |  |                                                                                                 |                                                                                                                         |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





94 33982

Item #8,10g,20b,22 Film # G 716 Per Funeral Home N.A.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                         |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JAMES A. CARTER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>19</b> YEAR <b>1994</b>                                                                                                                              |  | 3. TIME OF DEATH<br><b>4:05 P M</b>                                                             |                                                                                                                                         |
| 4. SOCIAL SECURITY NUMBER<br><b>215-03-1738</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>81</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>2/6/13</b>                                            |                                                                                                                                         |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>St. Agnes Hospital 900 S. Caton Ave.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Balto., MD.</b>                                                                                                                                       |  | 9c. COUNTY OF DEATH                                                                             |                                                                                                                                         |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                         |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 10b. COUNTY                                                                                                                                                                                                                                                                                    |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                                                                                                                                                 |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |                                                                                                                                         |
| 10e. STREET AND NUMBER<br><b>4515 Manordene Road</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  | 10f. ZIP CODE<br><b>21229</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                                           |                                                                                                                                         |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                           |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>black</b>                         |                                                                                                                                         |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5th grade</b><br>College (1-4 or 5+) <b>College</b>                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Sexton</b>                                                                     |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Unitarian Church</b>                                       |                                                                                                                                         |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>David Carter</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Fannie Epps Carter</b>                                                                                                                  |  |                                                                                                 |                                                                                                                                         |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Donald Carter</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4301 Norfolk Ave.</b>                                                                       |  |                                                                                                 |                                                                                                                                         |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                    |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>King Memorial Park 11/22/94</b>                                                                                                                                                                          |  | 20c. LOCATION — City or Town, State<br><b>Randallstown, Md.</b>                                                                                                                                 |  | 20d. DATE<br><b>11/22</b>                                                                       |                                                                                                                                         |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Joseph R. Watter, Jr.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Unity Funeral Home 108 W. North Ave. Balto., MD. 21201</b>                                                                                               |  |                                                                                                 |                                                                                                                                         |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. <b>ASYSTOLE OF THE HEART</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>Cerebral vascular accident</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>Hypertension</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Approximate Interval Between Onset and Death<br><b>1 DAY</b><br><b>10 YEARS</b> |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 | PART II. Other significant conditions contributing to death but not resulting in the underlying causes given in Part I.                 |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                         |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                         |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide                                                                                                                                                                                                                                                                                                |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |                                                                                                                                         |
| 28d. DESCRIBE NOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                          |  |                                                                                                 |                                                                                                                                         |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                    |  |                                                                                                 |                                                                                                                                         |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                         |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>040085</b>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/17/94</b>                                          |                                                                                                                                         |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>900 S. CATON AVENUE BALTIMORE, MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                         |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 21 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>                                                                                                                                       |  |                                                                                                 |                                                                                                                                         |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33983

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                   |  |                                                                                                 |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>CLARENCE EDWARD COFIELL</b>                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                 |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 16, 1994</b>                                                                                                                                    |  | 3. TIME OF DEATH<br>HOURS MIN. SEC.<br><b>18:13 P M</b>                                         |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217 01 8032</b>                                                                                                                                                                                                                                                                                                                                                                                  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                      |  | 8. AGE (In yrs. last birthday)<br><b>87</b> YRS.                                                                                                                                                  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>May 20, 1907</b>                                      |  |
| 8a. FACILITY NAME (If not institution, give street and number)<br><b>St. Agnes Hospital</b>                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                 |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>                                                                                                                                      |  | 9c. COUNTY OF DEATH<br><b>=</b>                                                                 |  |
| 10a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                         |  | 10b. COUNTY<br><b>Baltimore</b>                                                                                                                                                                                                                                                                 |  | 10c. CITY, TOWN OR LOCATION<br><b>Catonsville</b>                                                                                                                                                 |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>419 Oella Ave.</b>                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                 |  | 10f. ZIP CODE<br><b>21228</b>                                                                                                                                                                     |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                           |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                      |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>High School</b>                                                                                                                                                                                                                                                                                                             |  | College (1-4 or 5 +)<br><b>+2</b>                                                                                                                                                                                                                                                               |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Weaver</b>                                                                       |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Woolen Mill</b>                                            |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Clarence Elmer Cofiell</b>                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                 |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mammie Elizabeth Phillips</b>                                                                                                             |  |                                                                                                 |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>John E. Cofiell</b>                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                 |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>419 Oella Ave. Catonsville, Md. 21228</b>                                                     |  |                                                                                                 |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>New Oakland Cemetery November 19, 1994</b>                                                                                                                                                                |  | 20c. LOCATION — City or Town, State<br><b>Sykesville, Md.</b>                                                                                                                                     |  |                                                                                                 |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Harry W. Hight</i>                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                 |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Haight Funeral Home</b><br><b>P.O. Box 195 Sykesville, Md. 21784</b>                                                                                       |  |                                                                                                 |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                   |  |                                                                                                 |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →                                                                                                                                                                                                                                                                                                                                                                |  | a. <i>Acute Myocardial Infarction</i><br>DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                       |  |                                                                                                                                                                                                   |  |                                                                                                 |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                       |  | b. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                   |  |                                                                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | c. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                   |  |                                                                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | d. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                   |  |                                                                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                   |  |                                                                                                 |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Chronic Obstructive Pulmonary Disease</i><br><i>Heavy Smoker</i>                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                   |  |                                                                                                 |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                 |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                       |  |                                                                                                 |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                   |  |                                                                                                 |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                       |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                   |  |                                                                                                 |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide                                                                                                                                                   |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                          |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                          |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO            |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                               |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                            |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                   |  |                                                                                                 |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Belmont Hight</i>                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                 |  | 29c. LICENSE NUMBER<br><b>D38543</b>                                                                                                                                                              |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/16/94</b>                                          |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                   |  |                                                                                                 |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 19 1994</b>                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                 |  | 32. REGISTRAR'S SIGNATURE<br><i>John Benson Anderson</i>                                                                                                                                          |  |                                                                                                 |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.




IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33984

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                           |  |                                                                                                                                              |                                                                                                                                         |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ANNETTE W. DAVIS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 2. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>17</b> YEAR <b>94</b>                                                                                                                                                                                                                          |  | 3. TIME OF DEATH<br><b>7:25</b> p m                                                                                                          |                                                                                                                                         |
| 4. SOCIAL SECURITY NUMBER<br><b>218-07-9597</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                |  | 6. AGE (In yrs. last birthday)<br><b>79</b> YRS.                                                                                             |                                                                                                                                         |
| 7. DATE OF BIRTH (Month, Day, Year)<br><b>September 30, 1915</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                                                                                                                                                                                                                               |  |                                                                                                                                              |                                                                                                                                         |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Stella Maris Hospice</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Towson</b>                                                                                                                                                                                                                                      |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>                                                                                                      |                                                                                                                                         |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 10b. COUNTY<br><b>Baltimore</b>                                                                                                                                                                                                                                                           |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                                                                                              |                                                                                                                                         |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 10e. STREET AND NUMBER<br><b>3 Rock Creek Ct.</b>                                                                                                                                                                                                                                         |  | 10f. ZIP CODE<br><b>21234</b>                                                                                                                |                                                                                                                                         |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                            |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |                                                                                                                                         |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                                                                                                                                                                                                                |  |                                                                                                                                              |                                                                                                                                         |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12 yrs</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>                                                                                                                                                            |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Own Home</b>                                                                                            |                                                                                                                                         |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Carl Meyer</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Johanna Jurgansen</b>                                                                                                                                                                                                             |  |                                                                                                                                              |                                                                                                                                         |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Lee W. Wright</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10504 Rollingwood Terr. Glen Allen, Va. 23060</b>                                                                                                                                     |  |                                                                                                                                              |                                                                                                                                         |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Hilltop Service Corp. 11-19 Towson, Md.</b>                                                                                                                                                         |  | 20c. LOCATION — City or Town, State                                                                                                          |                                                                                                                                         |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204</b>                                                                                                                                                                                 |  |                                                                                                                                              |                                                                                                                                         |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cerebrovascular Accident</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. <b>Cerebrovascular Disease</b><br>c.<br>d.<br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. |  |                                                                                                                                                                                                                                                                                           |  |                                                                                                                                              | Approximate interval Between Onset and Death<br><b>6 mths.</b>                                                                          |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                           |  |                                                                                                                                              | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                           |  |                                                                                                                                              | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                       |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide |  | 28. DATE OF INJURY (Month, Day, Year)                                                                                                        |                                                                                                                                         |
| 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                                                                                                                  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                  |                                                                                                                                         |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                    |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                 |                                                                                                                                         |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                           |  |                                                                                                                                              |                                                                                                                                         |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 29c. LICENSE NUMBER<br><b>20390</b>                                                                                                                                                                                                                                                       |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/18/94</b>                                                                                       |                                                                                                                                         |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. Charles Hosch 5601 Loch Raven Blvd. Russell Morgan Bldg.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                           |  |                                                                                                                                              |                                                                                                                                         |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 21 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                          |  |                                                                                                                                              |                                                                                                                                         |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33985

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                                                                                                                             |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>PATRICK LEO DOLAN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |                                                  | 2. DATE OF DEATH<br>MONTH <b>Nov</b> DAY <b>16</b> YEAR <b>1994</b>                                                                                                                             |  | 3. TIME OF DEATH<br><b>2:45 am</b>                                                              |                                                                                                                                                                                                                                                             |
| 4. SOCIAL SECURITY NUMBER<br><b>213-07-4723</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                  | 6. AGE (In yrs. last birthday)<br><b>79</b> YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br><b>JULY 29, 1915</b>                                                                                                                                     |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>PENNSYLVANIA</b>                                 |                                                                                                                                                                                                                                                             |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Saint Joseph Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                             |                                                  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Towson, Maryland</b>                                                                                                                                  |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>                                                         |                                                                                                                                                                                                                                                             |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                                                                                                                             |
| 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 10b. COUNTY<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                             |                                                  | 10c. CITY, TOWN OR LOCATION<br><b>TOWSON</b>                                                                                                                                                    |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |                                                                                                                                                                                                                                                             |
| 10e. STREET AND NUMBER<br><b>804 MOCKINGBIRD LANE APT. 203</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                             |                                                  | 10f. ZIP CODE<br><b>21286</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                     |                                                                                                                                                                                                                                                             |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                |                                                  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                         |                                                                                                                                                                                                                                                             |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>MANUFACTURERS REP.</b>                                                                                                                                                     |                                                  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>SALES</b>                                                                                                                                                  |  |                                                                                                 |                                                                                                                                                                                                                                                             |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>THOMAS EDWARD DOLAN, SR.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                             |                                                  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>LUCILLA FOX</b>                                                                                                                         |  |                                                                                                 |                                                                                                                                                                                                                                                             |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>REGINA R. DOLAN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                             |                                                  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>804 MOCKINGBIRD LANE TOWSON, MD. 21286</b>                                                  |  |                                                                                                 |                                                                                                                                                                                                                                                             |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>HILLTOP SERVICE CORP. 11/17/94</b>                                                                                                                                                                    |                                                  | 20c. LOCATION — City or Town, State<br><b>TOWSON, MD.</b>                                                                                                                                       |  |                                                                                                 |                                                                                                                                                                                                                                                             |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>John E. Dolan</i> <b>JOHN E. DOLAN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                             |                                                  | 22. NAME AND ADDRESS OF FACILITY<br><b>RUCK TOWSON FUNERAL HOME INC.<br/>1050 YORK ROAD TOWSON, MD. 21204</b>                                                                                   |  |                                                                                                 |                                                                                                                                                                                                                                                             |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><b>a. LEFT LOWER LUNG PNEUMONIA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>b. DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>c. DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>d. DUE TO (OR AS A CONSEQUENCE OF):</b> |  |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                                 |  |                                                                                                 | Approximate Interval Between Onset and Death<br><b>3DAYS</b>                                                                                                                                                                                                |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>MULTIPLE CEREBROVASCULAR ACCIDENT</b><br><b>ATRIAL FIBRILLATION</b><br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                                 |  |                                                                                                 | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                                                                                                                             |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                                     |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                      |                                                  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |                                                                                                                                                                                                                                                             |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                             |                                                  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                               |  |                                                                                                 |                                                                                                                                                                                                                                                             |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                             |                                                  | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                    |  |                                                                                                 |                                                                                                                                                                                                                                                             |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                                                                                                                             |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                             |                                                  | 29c. LICENSE NUMBER<br><b>D 17728</b>                                                                                                                                                           |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11-16-94</b>                                          |                                                                                                                                                                                                                                                             |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>BA YIN OUNG, M.D., 8022 BELAIR ROAD, BALTIMORE, MD. 21236</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                                                                                                                             |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 21 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                             |                                                  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                                                                                                                             |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





94 33986

Item 19b, 9-717, 11-23-94, per F.H., dr

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                     |  |                                                                                                           |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ANNA ELSTE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                          |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOV 21 94</b>                                                                                                                                              |  | 3. TIME OF DEATH<br><b>1:00 A. M</b>                                                                      |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-22-0044</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                           |  | 6. AGE (In yrs. last birthday)<br><b>96</b> YRS.                                                                                                                                                    |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>2-17-98</b>                                                     |  |
| 8. FACILITY NAME (If not institution, give street and number)<br><b>Church Home</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                          |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>                                                                                                                                        |  | 9c. COUNTY OF DEATH<br><b>N/A</b>                                                                         |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                          |  | 10b. COUNTY<br><b>N/A</b>                                                                                                                                                                           |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore City</b>                                                      |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                          |  | 10e. STREET AND NUMBER<br><b>101 N. Bond Street</b>                                                                                                                                                 |  |                                                                                                           |  |
| 10f. ZIP CODE<br><b>21231</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                          |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                      |  |                                                                                                           |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                         |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>white</b>                                |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 8+)<br><b>1 year</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Secretary</b>                                                                                                                                                                           |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Rubber Company- Cemetery</b>                                                                                                                                   |  |                                                                                                           |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Otto Rosenbauer</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                          |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Marie Pemsel</b>                                                                                                                            |  |                                                                                                           |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs. Alice Brown</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                          |  | 19b. MAILING ADDRESS (13 Devon Hill Rd. C-3, Baltimore, Maryland 21210)<br><b>6639 Walnutwood Cir. Baltimore, Maryland 21212</b>                                                                    |  |                                                                                                           |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                            |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Parkwood Cemetery</b>                                                                                                                                                                                                       |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Maryland</b>                                                                                                                                   |  |                                                                                                           |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>George Ferrante</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                          |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Mitchell-Wiedefeld Home<br/>6500 York Road Baltimore, Maryland 21212</b>                                                                                     |  |                                                                                                           |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Alzheimers disease / advanced</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                     |  | Approximate Interval Between Onset and Death<br><b>years</b>                                              |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                     |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                     |  |                                                                                                           |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                                           |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                  |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                   |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                     |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                      |  |
| 28d. DESCRIBE HOW INJURY OCCURED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                        |  |                                                                                                           |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                     |  |                                                                                                           |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Elias Abboud, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                          |  | 29c. LICENSE NUMBER<br><b>043235</b>                                                                                                                                                                |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/21/94</b>                                                    |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Elias Abboud M.D. Church Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                     |  |                                                                                                           |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 21 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                          |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Radell</b>                                                                                                                                           |  |                                                                                                           |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33987

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                    |  |                                                                                                                                                      |  |                                                                         |                                                                                                                                                                                     |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>WILLIAM L. EAST</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                    |  | 2. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>20</b> YEAR <b>94</b>                                                                                     |  | 3. TIME OF DEATH<br><b>10:15 p. M</b>                                   |                                                                                                                                                                                     |
| 4. SOCIAL SECURITY NUMBER<br><b>215-10-3267</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 5. SEX<br><b>1</b> M <b>2</b> F                                                                                                    |  | 6. AGE (In yrs. last birthday)<br><b>81</b> YRS.                                                                                                     |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>7/14/13</b>                   |                                                                                                                                                                                     |
| 8a. FACILITY NAME (If not institution, give street and number)<br><b>Fort Howard Veterans Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                    |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br><b>Fort Howard/N. Point</b>                                                                                   |  | 8c. COUNTY OF DEATH<br><b>Baltimore</b>                                 |                                                                                                                                                                                     |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                    |  |                                                                                                                                                      |  |                                                                         |                                                                                                                                                                                     |
| 10a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 10b. COUNTY                                                                                                                        |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                                                                                                      |  | 10d. INSIDE CITY LIMITS?<br><b>1</b> YES <b>2</b> NO                    |                                                                                                                                                                                     |
| 10e. STREET AND NUMBER<br><b>3951 Benzinger Road</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                    |  | 10f. ZIP CODE<br><b>21229</b>                                                                                                                        |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                          |                                                                                                                                                                                     |
| 11. MARITAL STATUS<br><b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> YES <b>2</b> NO<br>IF YES, GIVE WAR OR DATES                                  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> YES <b>2</b> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>white</b> |                                                                                                                                                                                     |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5 +)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Painter</b>       |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>State Government</b>                                                                                            |  |                                                                         |                                                                                                                                                                                     |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William L. East</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                    |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Eva C. Hipp</b>                                                                              |  |                                                                         |                                                                                                                                                                                     |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Margaret East</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                    |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3951 Benzinger Road, Baltimore, MD 21229</b>     |  |                                                                         |                                                                                                                                                                                     |
| 20a. METHOD OF DISPOSITION<br><b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Loudon Park Cemetery 11/23 Baltimore, MD</b> |  | 20c. LOCATION — City or Town, State                                                                                                                  |  | 20d. LOCATION — City or Town, State                                     |                                                                                                                                                                                     |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                    |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Ambrose Funeral Home, Inc.<br/>1328 Sulphur Spring Rd. Arbutus, MD 21227</b>                                  |  |                                                                         |                                                                                                                                                                                     |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. CANCER OF LARYNX, LIVER METASTASIS</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                    |  |                                                                                                                                                      |  |                                                                         | Approximate Interval Between Onset and Death                                                                                                                                        |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/></b>                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                    |  |                                                                                                                                                      |  |                                                                         | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1</b> YES <b>2</b> NO                                                                                                                          |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> YES <b>2</b> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                    |  |                                                                                                                                                      |  |                                                                         | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA<br>OTHER: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) |
| 27. MANNER OF DEATH<br><b>1</b> Natural <b>5</b> Pending Investigation<br><b>2</b> Accident <b>6</b> Could not be determined<br><b>3</b> Suicide <b>4</b> Homicide                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                             |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                      |  | 28c. INJURY AT WORK?<br><b>1</b> YES <b>2</b> NO                        |                                                                                                                                                                                     |
| 28d. DESCRIBE HOW INJURY OCCURED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                    |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                               |  |                                                                         |                                                                                                                                                                                     |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                    |  | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                         |  |                                                                         |                                                                                                                                                                                     |
| 29a. CERTIFIER (Check only one)<br><b>1</b> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                             |  |                                                                                                                                    |  |                                                                                                                                                      |  |                                                                         |                                                                                                                                                                                     |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                    |  | 29c. LICENSE NUMBER<br><b>D30528</b>                                                                                                                 |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/20/94</b>                  |                                                                                                                                                                                     |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DR. DUGGIRALA, BALA M.D. 9600 NORTH POINT ROAD, FORT HOWARD, MARYLAND 21052</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                    |  |                                                                                                                                                      |  |                                                                         |                                                                                                                                                                                     |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 21 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                    |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                                                      |  |                                                                         |                                                                                                                                                                                     |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33988

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>George Lester Edgington</i>                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>Nov 19 94</i>                                                                                                                                          |  | 3. TIME OF DEATH<br><i>1045 P M</i>                                                             |  |
| 4. SOCIAL SECURITY NUMBER<br><i>281-26-0918</i>                                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br>YRS. MONTHS DAYS<br><i>11-01-17</i>                                                                                                                           |  | 7. DATE OF BIRTH (Month, Day, Year)<br><i>11-01-17</i>                                          |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>Keswick Nursing Home</i>                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>BALTIMORE CITY</i>                                                                                                                                    |  | 9c. COUNTY OF DEATH                                                                             |  |
| 10a. STATE<br><i>FLORIDA</i>                                                                                                                                                                                                                                                                                                                                                                                                 |  | 10b. COUNTY<br><i>LAKE COUNTY</i>                                                                                                                                                                                                                                                              |  | 10c. CITY, TOWN OR LOCATION<br><i>MT. DORA</i>                                                                                                                                                  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><i>1700 SANFORD</i>                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  | 10f. ZIP CODE<br><i>32757</i>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>                                                  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                               |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><i>WWII</i>                                                                                                                                 |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>WHITE</i>                         |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>8th GRADE</i><br>College (1-4 or 5+) <i>College</i>                                                                                                                                                                                                                                                                        |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><i>SALES AND SERVICE</i>                                                                                                                                                         |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>SELF-EMPLOYED</i>                                                                                                                                          |  |                                                                                                 |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>ALBERT EDGINGTON</i>                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>MAUDE SHEELEY</i>                                                                                                                       |  |                                                                                                 |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>K EDGINGTON</i>                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>3004 KESWICK ROAD BALTO., MD. 21211</i>                                                     |  |                                                                                                 |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>HILLCREST CEMETERY</i>                                                                                                                                                                                   |  | 20c. LOCATION — City or Town, State<br><i>LEESBURG, FLORIDA</i>                                                                                                                                 |  |                                                                                                 |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Debra L. Galt</i>                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><i>HUBBARD FUNERAL HOME<br/>4107 WILKENS AVE. BALTO., MD. 21229</i>                                                                                         |  |                                                                                                 |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Atherosclerotic Cardio Vascular disease</i>                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Significant Brady cardia</i>                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                              |  |                                                                                                 |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined                                                                                                                                                |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                        |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                              |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                          |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Joseph W. Edgington MD</i>                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><i>022334</i>                                                                                                                                                            |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>NOV 20 94</i>                                         |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Joseph W. Edgington MD 700 W 41st STREET Balto MD 21211</i>                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |
| 31. DATE FILED (Month, Day, Year)<br><i>NOV 21 1994</i>                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                 |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33989

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                 |  |                                                                                                                                         |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Joseph Marcellus Edwards                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                           |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>November 18, 1994                                                                                                                                         |  | 3. TIME OF DEATH<br>3:30 P.M.                                                                                                           |  |
| 4. SOCIAL SECURITY NUMBER<br>212-03-3015                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                                |  | 6. AGE (In yrs. last birthday)<br>85 YRS.                                                                                                                                                       |  | 7. DATE OF BIRTH (Month, Day, Year)<br>April 27, 1909                                                                                   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>1802 Mayfield Avenue,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                           |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore (Halethorpe)                                                                                                                                   |  | 9c. COUNTY OF DEATH<br>Baltimore                                                                                                        |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                 |  |                                                                                                                                         |  |
| 10a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 10b. COUNTY<br>Baltimore                                                                                                                                                                                                                                                                                  |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore (Halethorpe)                                                                                                                                           |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                         |  |
| 10e. STREET AND NUMBER<br>1802 Mayfield Avenue,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                           |  | 10f. ZIP CODE<br>21227                                                                                                                                                                          |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA                                                                                                    |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                              |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                                                        |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>10th Grade                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Estimator                                                                                                                                                                                |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Maryland Shipbuilding and Drydock Co.                                                                                                                         |  |                                                                                                                                         |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Charles Edwards                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                           |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Agnes Miller                                                                                                                               |  |                                                                                                                                         |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mrs. Patricia Monaghan                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                           |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1802 Mayfield Ave., Baltimore, Md. 21227                                                       |  |                                                                                                                                         |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                        |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Meadowridge Memorial Pk. 11/21                                                                                                                                                                                         |  | 20c. LOCATION — City or Town, State<br>Elkridge, Maryland                                                                                                                                       |  |                                                                                                                                         |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Kevin E. Ecker                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                           |  | 22. NAME AND ADDRESS OF FACILITY<br>McCully Funeral Home of Brooklyn<br>237 E. Patapsco Ave., Balto., Md. 21225                                                                                 |  |                                                                                                                                         |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Congestive heart failure</i><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <i>Coronary and rheumatic heart disease</i><br>c. <i>Uremia due to nephrosclerosis</i><br>d. <i>anemia chronic disease</i> |  |                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                 |  |                                                                                                                                         |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                 |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                 |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                                                         |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Sulfide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Nomicide                                                                                                                                                                                                                                                                                            |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                    |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                        |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                    |  | 28e. DESCRIBE NOW INJURY OCCURED                                                                                                                                                                |  |                                                                                                                                         |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                             |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Eugene B. Benitez, M.D.                                                                                                                                                                                                                                          |  | 29c. LICENSE NUMBER<br>D20028                                                                                                                                                                   |  | 29d. DATE SIGNED (Month, Day, Year)<br>Nov 19/94                                                                                        |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Dr. Eugene B. Benitez, M.D. 3455 Wilkens Ave., Baltimore, Maryland 21229                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                 |  |                                                                                                                                         |  |
| 31. DATE FILED (Month, Day, Year)<br>NOV 21 1994                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                           |  | 32. REGISTRAR'S SIGNATURE<br>Julia [Signature]                                                                                                                                                  |  |                                                                                                                                         |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





94 33990

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                |                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                    |                                                                                                |                                                                      |                                                         |    |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|---------------------------------------------------------|----|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>EDWARD J GLASPER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                |                                                                                                                                                                                                                                                                                                      |  | 2. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>16</b> YEAR <b>94</b>                                                                                                                                |  | 3. TIME OF DEATH<br><b>8 P M</b>                                                                |                                                                                                                                                    |                                                                                                |                                                                      |                                                         |    |
| 4. SOCIAL SECURITY NUMBER<br><b>220 01 3948</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                           |  | 6. AGE (In yrs. last birthday)<br><b>80</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH<br>(Month/Day/Year)<br><b>10/16/14</b>                                         |                                                                                                                                                    |                                                                                                |                                                                      |                                                         |    |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>md</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                |                                                                                                                                                                                                                                                                                                      |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>SINAI</b>                                                                                                                  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>                                         |                                                                                                                                                    |                                                                                                |                                                                      |                                                         |    |
| 9c. COUNTY OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                |                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                    |                                                                                                |                                                                      |                                                         |    |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                |                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                    |                                                                                                |                                                                      |                                                         |    |
| 10a. STATE<br><b>md</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                | 10b. COUNTY                                                                                                                                                                                                                                                                                          |  | 10c. CITY, TOWN OR LOCATION<br><b>Balto</b>                                                                                                                                                     |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |                                                                                                                                                    |                                                                                                |                                                                      |                                                         |    |
| 10e. STREET AND NUMBER<br><b>3333 Alto Rd</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                |                                                                                                                                                                                                                                                                                                      |  | 10f. ZIP CODE<br><b>21216</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>                                                   |                                                                                                                                                    |                                                                                                |                                                                      |                                                         |    |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                      |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                         |                                                                                                                                                    |                                                                                                |                                                                      |                                                         |    |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9th</b> College (1-4 or 5+) <b></b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                |                                                                                                                                                                                                                                                                                                      |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Custodian</b>                                                               |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>American Red Cross</b>                                     |                                                                                                                                                    |                                                                                                |                                                                      |                                                         |    |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Edward Glasper</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                |                                                                                                                                                                                                                                                                                                      |  | 18. MOTHER'S NAME (First, Middle, Maiden, Surname)<br><b>Susie Parham</b>                                                                                                                       |  |                                                                                                 |                                                                                                                                                    |                                                                                                |                                                                      |                                                         |    |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Lloyd Glasper</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                |                                                                                                                                                                                                                                                                                                      |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5707 Rubin Ave Balto, md 21215</b>                                                          |  |                                                                                                 |                                                                                                                                                    |                                                                                                |                                                                      |                                                         |    |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                |                                                                                                                                                                                                                                                                                                      |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place)<br><b>Arbutus Memorial Pk</b> DATE <b>11/16/94</b>                                                             |  | 20c. LOCATION — City or Town, State<br><b>Arbutus, md</b>                                       |                                                                                                                                                    |                                                                                                |                                                                      |                                                         |    |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Sela March</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                |                                                                                                                                                                                                                                                                                                      |  | 22. NAME AND ADDRESS OF FACILITY<br><b>March F. H-West</b><br><b>4300 Wabash Ave</b>                                                                                                            |  |                                                                                                 |                                                                                                                                                    |                                                                                                |                                                                      |                                                         |    |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sepsis - Gram + cocci</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><table border="1"> <tr> <td>a. DUE TO (OR AS A CONSEQUENCE OF):<br/><b>Uremia (Dialysis Dependent)</b></td> <td rowspan="4">Approximate Interval Between Onset and Death<br/><b>2 days</b><br/><b>4 days</b><br/><b>1 day</b></td> </tr> <tr> <td>b. DUE TO (OR AS A CONSEQUENCE OF):<br/><b>Hepatic Encephalopathy</b></td> </tr> <tr> <td>c. DUE TO (OR AS A CONSEQUENCE OF):<br/><b>Pneumonia</b></td> </tr> <tr> <td>d.</td> </tr> </table> |                                                                                                |                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                 |  |                                                                                                 | a. DUE TO (OR AS A CONSEQUENCE OF):<br><b>Uremia (Dialysis Dependent)</b>                                                                          | Approximate Interval Between Onset and Death<br><b>2 days</b><br><b>4 days</b><br><b>1 day</b> | b. DUE TO (OR AS A CONSEQUENCE OF):<br><b>Hepatic Encephalopathy</b> | c. DUE TO (OR AS A CONSEQUENCE OF):<br><b>Pneumonia</b> | d. |
| a. DUE TO (OR AS A CONSEQUENCE OF):<br><b>Uremia (Dialysis Dependent)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Approximate Interval Between Onset and Death<br><b>2 days</b><br><b>4 days</b><br><b>1 day</b> |                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                    |                                                                                                |                                                                      |                                                         |    |
| b. DUE TO (OR AS A CONSEQUENCE OF):<br><b>Hepatic Encephalopathy</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                |                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                    |                                                                                                |                                                                      |                                                         |    |
| c. DUE TO (OR AS A CONSEQUENCE OF):<br><b>Pneumonia</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                |                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                    |                                                                                                |                                                                      |                                                         |    |
| d.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                |                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                    |                                                                                                |                                                                      |                                                         |    |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>HTN, NIDDM, Shock Liver/Hepatic Encephalopathy, Seizures,</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                |                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                 |  |                                                                                                 | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                              |                                                                                                |                                                                      |                                                         |    |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                |                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                 |  |                                                                                                 | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |                                                                                                |                                                                      |                                                         |    |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> 4 Nursing Home <input type="checkbox"/> 5 Residence <input type="checkbox"/> 6 Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                    |                                                                                                |                                                                      |                                                         |    |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide <input type="checkbox"/> Not determined                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                               |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |                                                                                                                                                    |                                                                                                |                                                                      |                                                         |    |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                |                                                                                                                                                                                                                                                                                                      |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                    |  |                                                                                                 |                                                                                                                                                    |                                                                                                |                                                                      |                                                         |    |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                |                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                    |                                                                                                |                                                                      |                                                         |    |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>John P. Hakim, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                |                                                                                                                                                                                                                                                                                                      |  | 29c. LICENSE NUMBER                                                                                                                                                                             |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/16/94</b>                                          |                                                                                                                                                    |                                                                                                |                                                                      |                                                         |    |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>John P. Hakim, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                |                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                 |  |                                                                                                 |                                                                                                                                                    |                                                                                                |                                                                      |                                                         |    |
| 31. DATE FILED (Month, Day, Year)<br><b>11/16 NOV 21 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                |                                                                                                                                                                                                                                                                                                      |  | 32. REGISTRAR'S SIGNATURE<br><b>John A. Harrison</b>                                                                                                                                            |  |                                                                                                 |                                                                                                                                                    |                                                                                                |                                                                      |                                                         |    |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS

TO THE HOSPITAL OR EXTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33991

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                              |                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ALTHEA DAY GUBA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 2. DATE OF DEATH<br>MONTH <b>NOV.</b> DAY <b>16,</b> YEAR <b>1994</b>                                                                                                                                                                                                                          |  | 3. TIME OF DEATH<br><b>10:40 A M</b>                                                                                                         |                                              |
| 4. SOCIAL SECURITY NUMBER<br><b>215-07-2656</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>79</b> YRS.                                                                                             |                                              |
| 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>SEPT. 21, 1915</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>MISSISSIPPI</b>                                                                                                                                                                                                                                 |  |                                                                                                                                              |                                              |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>3022 EAST AVENUE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>                                                                                                                                                                                                                                        |  | 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>                                                                                                      |                                              |
| 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 10b. COUNTY<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                                |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>                                                                                              |                                              |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 10e. STREET AND NUMBER<br><b>3022 EAST AVENUE</b>                                                                                                                                                                                                                                              |  | 10f. ZIP CODE<br><b>21234</b>                                                                                                                |                                              |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                 |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |                                              |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>                                                                                                                                                                                                                     |  |                                                                                                                                              |                                              |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>2</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOUSEWIFE</b>                                                                                                                                                              |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>AT HOME</b>                                                                                             |                                              |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>ROGER TROUT DAY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>ANNA MARY GRUEL</b>                                                                                                                                                                                                                    |  |                                                                                                                                              |                                              |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>WILLIAM H. GUBA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3022 EAST AVENUE BALTIMORE, MD. 21234</b>                                                                                                                                                  |  |                                                                                                                                              |                                              |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify)<br><b>ENTOMBMENT</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>DULANEY VALLEY MAUS. 11/19/94</b>                                                                                                                                                                        |  | 20c. LOCATION — City or Town, State<br><b>TIMONIUM, MD.</b>                                                                                  |                                              |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>John E. Dolan</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>RUCK TOWSON FUNERAL HOME INC.<br/>1050 YORK ROAD TOWSON, MD. 21204</b>                                                                                                                                                                                  |  |                                                                                                                                              |                                              |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CORONARY ARTERY DISEASE</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><br>a. <b>PERIPHERAL VASCULAR DISEASE</b><br>b. <b>TYPE I DIABETES MELLITUS</b><br>c.<br>d.<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b> |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                              | Approximate Interval Between Onset and Death |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                             |  |                                                                                                                                              |                                              |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                              |                                              |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY                                                                                                                          |                                              |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                              |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                 |                                              |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                              |                                              |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John A. Lavin</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 29c. LICENSE NUMBER<br><b>D20795</b>                                                                                                                                                                                                                                                           |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11-17-94</b>                                                                                       |                                              |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DR. JOHN LAVIN 6212 YORK ROAD BALTIMORE, MD.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                              |                                              |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 21 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 32. REGISTRAR'S SIGNATURE<br><i>John A. Lavin</i>                                                                                                                                                                                                                                              |  |                                                                                                                                              |                                              |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33992

Item#19.b G-film 717 per F.H 11/21/94 P.C

1 -  
FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                    |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Wanda E. Hamric</b>                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>20</b> YEAR <b>94</b>                                                                                                                                |  | 3. TIME OF DEATH<br><b>6:30 a m</b>                                                                                                                |  |
| 4. SOCIAL SECURITY NUMBER<br><b>151-18-4888</b>                                                                                                                                                                                                                                                                                                                                                                                                      |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                     |  | 6. AGE (In yrs. last birthday)<br><b>72</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>8-5-22</b>                                                                                               |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Johns Hopkins Bayview Medical Center</b>                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>                                                                                                                                         |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>                                                                                                            |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                    |  |
| 10a. STATE<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 10b. COUNTY<br><b>Baltimore</b>                                                                                                                                                                                                                                                                |  | 10c. CITY, TOWN OR LOCATION<br><b>Dundalk</b>                                                                                                                                                   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                    |  |
| 10e. STREET AND NUMBER<br><b>75 Kinship</b>                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  | 10f. ZIP CODE<br><b>21222</b>                                                                                                                                                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                        |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                       |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                            |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>4</b>                                                                                                                                                                                                                                                                                                                                                                       |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife</b>                                                                                                                                                              |  | 16b. KIND OF BUSINESS/INDUSTRY                                                                                                                                                                  |  |                                                                                                                                                    |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John May</b>                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)                                                                                                                                               |  |                                                                                                                                                    |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Linda McNeil</b>                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route)<br><b>6614 Woods Pkwy. <del>Baltimore</del>, Md. 21222</b>                                                                              |  |                                                                                                                                                    |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metro Crematory 11/21</b>                                                                                                                                                                                |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Md</b>                                                                                                                                     |  |                                                                                                                                                    |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Colt Connelly</b>                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Connelly Funeral Home of Dundalk<br/>7110 Sollers Pt Rd. 21222</b>                                                                                       |  |                                                                                                                                                    |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  | Approximate Interval Between Onset and Death                                                                                                       |  |
| a. <b>Metastatic lung cancer</b><br>DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  | 2 yrs                                                                                                                                              |  |
| b. <b>Metastatic dz to brain</b><br>DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  | 6 mo.                                                                                                                                              |  |
| c. _____<br>DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                    |  |
| d. _____<br>DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                    |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                              |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                    |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                                                                    |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined                                                                                                                                                                        |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                 |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                       |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                         |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                    |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Dr. Wilb, MD</b>                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><b>AF2664200-057</b>                                                                                                                                                     |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11-20-94</b>                                                                                             |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Johns Hopkins Bayview Medical Center, Baltimore, MD</b>                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                 |  |                                                                                                                                                    |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 21 1994</b>                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  | 32. REGISTRAR'S SIGNATURE<br><b>John Benner-Rudolph</b>                                                                                                                                         |  |                                                                                                                                                    |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33993

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                     |  |                                                                                                                                             |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>LOUISA BOYD HILL</b>                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                          |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 21, 1994</b>                                                                                                                                      |  | 3. TIME OF DEATH<br><b>4:15 a M</b>                                                                                                         |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218-26-4273</b>                                                                                                                                                                                                                                                                                                                                                                                  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                           |  | 6. AGE (In yrs. last birthday)<br><b>64</b> YRS.                                                                                                                                                    |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>December 6, 1929</b>                                                                              |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>GREATER BALTIMORE MEDICAL CENTER</b>                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                          |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>TOWSON</b>                                                                                                                                                |  | 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>                                                                                                     |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                     |  |                                                                                                                                             |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  | 10b. COUNTY<br><b>Baltimore</b>                                                                                                                                                                                                                                                                          |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                                                                                                                                                     |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                         |  |
| 10e. STREET AND NUMBER<br><b>520 Castle Drive Apt. F</b>                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                          |  | 10f. ZIP CODE<br><b>21212</b>                                                                                                                                                                       |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                              |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                           |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                      |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>white</b>                                                                  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>12 years</b>                                                                                                                                                                                                                                                                                                                                            |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Payroll Supervisor</b>                                                                                                                                                               |  | 15b. KIND OF BUSINESS/INDUSTRY<br><b>Hospital</b>                                                                                                                                                   |  |                                                                                                                                             |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Milton Painter Hill</b>                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                          |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Louisa (unknown) Boyd</b>                                                                                                                   |  |                                                                                                                                             |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>John Beazley</b>                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                          |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1521 Rayville Road, Parkton, MD 21120</b>                                                       |  |                                                                                                                                             |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Greenmont Crematory November 22, 1994</b>                                                                                                                                                                          |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Maryland</b>                                                                                                                                   |  |                                                                                                                                             |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                          |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Mitchell-Wiedefeld Home Inc.<br/>6500 York Rd. Baltimore, MD 21212</b>                                                                                       |  |                                                                                                                                             |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                     |  |                                                                                                                                             |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                     |  |                                                                                                                                             |  |
| a. <b>Respiratory failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                     |  |                                                                                                                                             |  |
| b. <b>Emphysema</b><br>DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                     |  |                                                                                                                                             |  |
| c.<br>DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                     |  |                                                                                                                                             |  |
| d.<br>DUE TO (OR AS A CONSEQUENCE OF):                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                     |  |                                                                                                                                             |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>upper GI bleed</b>                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                     |  |                                                                                                                                             |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                     |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                     |  |                                                                                                                                             |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                                                                             |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 6 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                        |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                   |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                            |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                        |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                          |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                        |  |                                                                                                                                             |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                     |  |                                                                                                                                             |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                          |  | 29c. LICENSE NUMBER<br><b>226002</b>                                                                                                                                                                |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/21/94</b>                                                                                      |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>John H. Applec 120 Vista Place Dr Suite 205 Towson Md 21204</b>                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                     |  |                                                                                                                                             |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 21 1994</b>                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                          |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                       |  |                                                                                                                                             |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. For this FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

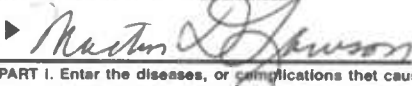




94 33994

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                         |  |                                                                                                                                                |                                                                                 |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>CLIFFORD A. S. HENNING JR</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 2. DATE OF DEATH<br>MONTH <b>NOV.</b> DAY <b>17</b> YEAR <b>94</b>                                                                                      |  | 3. TIME OF DEATH<br><b>5 P M</b>                                                                                                               |                                                                                 |
| 4. SOCIAL SECURITY NUMBER<br><b>215-09- 8127</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 5. SEX<br><b>1 XX M 2 F</b>                                                                                                                             |  | 6. AGE (In yrs. last birthday)<br><b>79</b> YRS.                                                                                               |                                                                                 |
| 7. DATE OF BIRTH (Month, Day, Year)<br><b>Aug. 19, 1915</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                                                                                             |  |                                                                                                                                                |                                                                                 |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Good Samaritan Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>                                                                                            |  | 9c. COUNTY OF DEATH<br><b>---</b>                                                                                                              |                                                                                 |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                         |  |                                                                                                                                                |                                                                                 |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 10b. COUNTY<br><b>---</b>                                                                                                                               |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore City</b>                                                                                           |                                                                                 |
| 10d. INSIDE CITY LIMITS?<br><b>1 YES 2 NO</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                         |  |                                                                                                                                                |                                                                                 |
| 10e. STREET AND NUMBER<br><b>#8205, 6225 York Road</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 10f. ZIP CODE<br><b>21212</b>                                                                                                                           |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                 |                                                                                 |
| 11. MARITAL STATUS<br><b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 YES 2 NO</b><br>IF YES, GIVE WAR OR DATES                                                              |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 YES XX NO</b> Specify: |                                                                                 |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                         |  |                                                                                                                                                |                                                                                 |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 years</b><br>College (1-4 or 5+) <b>College</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Expeditor</b>                          |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Areospace Contractor</b>                                                                                  |                                                                                 |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Clifford A. S. Henning, Sr.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Nellie Mae Greiner</b>                                                                          |  |                                                                                                                                                |                                                                                 |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Gail H. Simpson (Daughter)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>819 Mildred Avenue, Baltimore, Maryland 21222</b>   |  |                                                                                                                                                |                                                                                 |
| 20a. METHOD OF DISPOSITION<br><b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Baltimore Cemetery 11/21</b>                                      |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Maryland</b>                                                                              |                                                                                 |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Mitchell-Wiedefeld Home 6500 York Road, Baltimore, MD 21212</b>                                                  |  |                                                                                                                                                |                                                                                 |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>PNEUMONIA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>COPD</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>LUNG CANCER</b> |  |                                                                                                                                                         |  |                                                                                                                                                | Approximate Interval Between Onset and Death<br><b>48 hrs</b><br><b>20 yrs.</b> |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>LUNG CANCER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                         |  |                                                                                                                                                | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1 YES 2 NO</b>                             |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1 YES 2 NO</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                         |  |                                                                                                                                                |                                                                                 |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1 YES 2 NO</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b><br>OTHER: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b> |  |                                                                                                                                                |                                                                                 |
| 27. MANNER OF DEATH<br><b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                  |  | 28b. TIME OF INJURY <b>M</b>                                                                                                                   |                                                                                 |
| 28c. INJURY AT WORK?<br><b>1 YES 2 NO</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                       |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                   |                                                                                 |
| 29a. CERTIFIER<br>(Check only one)<br><b>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b><br><b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>                                                                                                                                                                                                                                                                       |  |                                                                                                                                                         |  |                                                                                                                                                |                                                                                 |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Nizar Charafeddine</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 29c. LICENSE NUMBER<br><b>D45484</b>                                                                                                                    |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>NOV 17 94</b>                                                                                        |                                                                                 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>NIZAR CHARAFEDDINE 5601 LOCH RAVEN BLVD, BALT, MD 21239</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                         |  |                                                                                                                                                |                                                                                 |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 21 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                         |  |                                                                                                                                                |                                                                                 |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Item # 1,15,16,17,18,19 Film # G 716 11-21-94 N.A. Per FunerAl Home

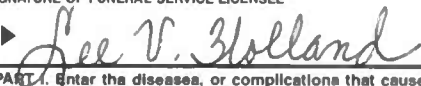
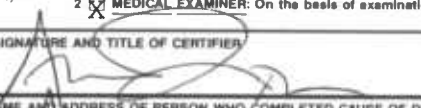
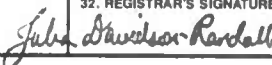
1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                             |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JAMES Junior HOBBS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                             |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOV 18 94</b>                                                                                                                                          |  | 3. TIME OF DEATH<br><b>9:51 p.m.</b>                                                        |  |
| 4. SOCIAL SECURITY NUMBER<br><b>258-26-0359</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                  |  | 6. AGE (In yrs. last birthday)<br><b>69</b> YRS.                                                                                                                                                |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>APR. 10, 1925</b>                                 |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>GEORGIA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>HARBOR HOSPITAL</b>                                                                                                                                                                                                    |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>                                                                                                                                    |  | 9c. COUNTY OF DEATH<br><b>n/a</b>                                                           |  |
| 10a. STATE<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                             |  | 10b. COUNTY<br><b>n/a</b>                                                                                                                                                                       |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>                                             |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                             |  | 10e. STREET AND NUMBER<br><b>2436 HOLLINS FERRY ROAD</b>                                                                                                                                        |  |                                                                                             |  |
| 10f. ZIP CODE<br><b>21230</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                             |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>UNITED STATES</b>                                                                                                                                           |  |                                                                                             |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                     |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>Grade School</b><br>College (1-4 or 5+) <b>—</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>LABORER</b>                                                                                                                                                                |  | 16. KIND OF BUSINESS/INDUSTRY<br><b>Upholstery Company</b><br><b>n/a</b>                                                                                                                        |  |                                                                                             |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>ARCHIE HOBBS Archie Hobbs</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                             |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Sally Hobbs</b>                                                                                                                         |  |                                                                                             |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>ETHEL HOBBS Ethel Hobbs</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                             |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2436 HOLLINS FERRY ROAD, BALTIMORE, MD 21230</b>                                            |  |                                                                                             |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                 |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>MT. ZION CEMETERY</b>                                                                                                                                                                                 |  | 20c. DATE<br><b>11-22</b>                                                                                                                                                                       |  | 20d. LOCATION — City or Town, State<br><b>LANSLOWNE, MARYLAND</b>                           |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                             |  | 22. NAME AND ADDRESS OF FACILITY<br><b>WM. C. MARCH FH.-1101 E. NN AVENUE</b>                                                                                                                   |  |                                                                                             |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Hypertensive atherosclerotic Cardiovascular Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>a. <b>—</b><br>b. <b>—</b><br>c. <b>—</b><br>d. <b>—</b><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>—</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                             |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                              |  |                                                                                             |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                         |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>—</b>                                                                                                                                                                                                                                          |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                 |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED<br><b>—</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>—</b>                                                                                                                                                                                          |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>—</b>                                                                                                        |  |                                                                                             |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                             |  | 29c. LICENSE NUMBER<br><b>O.C.M.E.</b>                                                                                                                                                          |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>NOV 19, 1994</b>                                  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                             |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 21 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                            |  |                                                                                                                                                                                                 |  |                                                                                             |  |

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |                                                                                                                                                     |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><del>MAJED</del> Maged S. Hamadeh<br><del>S.</del> HAMADEH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>NOVEMBER 20, 1994                                                                                                                                             |  | 3. TIME OF DEATH<br>7:40 A M                                                         |                                                                                                                                                     |
| 4. SOCIAL SECURITY NUMBER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                                                                                                                                                             |  | 6. AGE (In yrs. last birthday)<br>49 YRS.                                                                                                                                                           |  | 7. DATE OF BIRTH (Month, Day, Year)<br>05/ 24/ 1945                                  |                                                                                                                                                     |
| 8. BIRTHPLACE (State or Foreign Country)<br>Lebanon                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  | 9. COUNTY OF DEATH                                                                                                                                                                                  |  |                                                                                      |                                                                                                                                                     |
| 9a. FACILITY NAME (If not institution, give street and number)<br>THE JOHNS HOPKINS HOSPITAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE CITY                                                                                                                                               |  | 9c. COUNTY OF DEATH                                                                  |                                                                                                                                                     |
| 10a. STATE<br>Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                            |  | 10b. COUNTY                                                                                                                                                                                         |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore                                             |                                                                                                                                                     |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                            |  | 10e. STREET AND NUMBER<br>218 North Charles Street Apt. 603                                                                                                                                         |  |                                                                                      |                                                                                                                                                     |
| 10f. ZIP CODE<br>21202                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |  | 10g. CITIZEN OF WHAT COUNTRY?<br>Lebanon                                                                                                                                                            |  |                                                                                      |                                                                                                                                                     |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                          |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                           |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                     |                                                                                                                                                     |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                            |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Real Estate Owner                                                                  |  | 16b. KIND OF BUSINESS/INDUSTRY                                                       |                                                                                                                                                     |
| 17. FATHER'S NAME (First, Middle, Last)<br>Sabri Hamadeh                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Zeinab Al-Asaad                                                                                                                                |  |                                                                                      |                                                                                                                                                     |
| 19a. INFORMANT'S NAME (Type/Print)<br>Ali Hamadeh                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                            |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>218 N. Charles St. Apt. 603 Balti. Md. 21202                                                       |  |                                                                                      |                                                                                                                                                     |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                 |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Hamadeh Cemetery                                                                                                                                                                                                        |  | 20c. LOCATION — City or Town, State<br>Hermel Lebanon                                                                                                                                               |  | 20d. DATE                                                                            |                                                                                                                                                     |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                            |  | 22. NAME AND ADDRESS OF FACILITY<br>David J. Weber Funeral Home<br>401 S. Chester Street Balti. Md. 21231                                                                                           |  |                                                                                      |                                                                                                                                                     |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Colon Cancer<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      | Approximate Interval Between Onset and Death<br>8 Years                                                                                             |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                           |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      | DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/> |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                     |  |                                                                                      |                                                                                                                                                     |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                       |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                     |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                            |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |                                                                                                                                                     |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                            |  | 28e. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                   |  |                                                                                      |                                                                                                                                                     |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |  | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                        |  |                                                                                      |                                                                                                                                                     |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |                                                                                                                                                     |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                            |  | 29c. LICENSE NUMBER<br>M5307                                                                                                                                                                        |  | 29d. DATE SIGNED (Month, Day, Year)<br>November 20, 1994                             |                                                                                                                                                     |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>5712 Roland Ave Apartment 2A Baltimore, MD 21210                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                     |  |                                                                                      |                                                                                                                                                     |
| 31. DATE FILED (Month, Day, Year)<br>NOV 21 1994                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |  | 32. REGISTRAR'S SIGNATURE<br>                                                                                                                                                                       |  |                                                                                      |                                                                                                                                                     |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



94 33997

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                          |  |                                                                                                                                                  |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Mary E Harrington</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                     |  | 2. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>19</b> YEAR <b>94</b>                                                                                                                                         |  | 3. TIME OF DEATH<br><b>11:20 P M</b>                                                                                                             |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-32-9633</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 5. SEX<br><b>1</b> <input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                 |  | 6. AGE (In yrs. last birthday)<br><b>89</b> YRS.                                                                                                                                                         |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>11/12/05</b>                                                                                           |  |
| 8a. FACILITY NAME (If not institution, give street and number)<br><b>Sinai Hospital of Balto</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                     |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore, MD</b>                                                                                                                                              |  | 8c. COUNTY OF DEATH<br><b>Baltimore City</b>                                                                                                     |  |
| 10a. STATE<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 10b. COUNTY<br><b>BALCO</b>                                                                                                                                                                                                                                                         |  | 10c. CITY, TOWN OR LOCATION<br><b>3206 Burning Well Rd, Balto MD</b>                                                                                                                                     |  | 10d. INSIDE CITY LIMITS?<br><b>1</b> <input type="checkbox"/> YES <input type="checkbox"/> NO                                                    |  |
| 10e. STREET AND NUMBER<br><b>3206 Burning Well Rd</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                     |  | 10f. ZIP CODE<br><b>21207</b>                                                                                                                                                                            |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                                      |  |
| 11. MARITAL STATUS<br><b>3</b> <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><b>1</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                            |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>                                                                       |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Teacher</b>                                                                                                                                                     |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Balto. City Schools</b>                                                                                                                                             |  |                                                                                                                                                  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William Johnson</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                     |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Adell Higginbottom</b>                                                                                                                           |  |                                                                                                                                                  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Nettie Harrington</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                     |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3206 Burning Well Rd. Balto., Md. 21207</b>                                                          |  |                                                                                                                                                  |  |
| 20a. METHOD OF DISPOSITION<br><b>1</b> <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Arbutus</b>                                                                                                                                                                                   |  | 20c. LOCATION — City or Town, State<br><b>11/23 Balto, Md.</b>                                                                                                                                           |  |                                                                                                                                                  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>James A. Morton</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                     |  | 22. NAME AND ADDRESS OF FACILITY<br><b>James A. Morton &amp; Sons<br/>1701 Laurens St. Balto., Md. 21217</b>                                                                                             |  |                                                                                                                                                  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Cardiac ARREST</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>b. Cerebrovascular Accident</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br><b>c.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br><b>d.</b> |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                          |  | Approximate interval Between Onset and Death<br><b>Minutes</b><br><b>2 days</b>                                                                  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                          |  | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                          |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1</b> <input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                          |  |                                                                                                                                                  |  |
| 27. MANNER OF DEATH<br><b>1</b> <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><b>2</b> <input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><b>3</b> <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                         |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                              |  | 28b. TIME OF INJURY<br><b>M</b>                                                                                                                                                                          |  | 28c. INJURY AT WORK?<br><b>1</b> <input type="checkbox"/> YES <input type="checkbox"/> NO                                                        |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                     |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                   |  |                                                                                                                                                  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                          |  |                                                                                                                                                  |  |
| 29a. CERTIFIER (Check only one)<br><b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                          |  |                                                                                                                                                  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Melinda Greenfield DO</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                     |  | 29c. LICENSE NUMBER<br><b>AS2402321MG</b>                                                                                                                                                                |  |                                                                                                                                                  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Melinda Greenfield Sinai Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                     |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/19/94</b>                                                                                                                                                   |  |                                                                                                                                                  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>NOV 21 1994</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                          |  |                                                                                                                                                  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                            |             |                                                                                                                                                                                                     |                                                                   |                                                                                      |                                                                         |                                                                                                           |                                                                                                     |                                                                                                                                             |  |                                         |  |                                                                 |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------|--|-----------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><u>Vernon E. Hornberger</u> <u>Vernon Edward Hornberger Sr.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |             | 2. DATE OF DEATH<br>MONTH <u>November</u> DAY <u>20</u> YEAR <u>1994</u>                                                                                                                            |                                                                   | 3. TIME OF DEATH<br><u>11:25 A</u> M                                                 |                                                                         |                                                                                                           |                                                                                                     |                                                                                                                                             |  |                                         |  |                                                                 |  |
| 4. SOCIAL SECURITY NUMBER<br><u>212-07-0258</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                                                                                                                                                             |             | 6. AGE (In yrs. last birthday)<br><u>89</u> YRS.                                                                                                                                                    |                                                                   | 7. DATE OF BIRTH (Month, Day, Year)<br><u>February 19, 1905</u>                      |                                                                         | 8. BIRTHPLACE (State or Foreign Country)<br><u>Maryland</u>                                               |                                                                                                     |                                                                                                                                             |  |                                         |  |                                                                 |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><u>Union Memorial Hospital</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                            |             | 9b. CITY, TOWN OR LOCATION OF DEATH<br><u>Baltimore City</u>                                                                                                                                        |                                                                   |                                                                                      |                                                                         | 9c. COUNTY OF DEATH                                                                                       |                                                                                                     |                                                                                                                                             |  |                                         |  |                                                                 |  |
| RESIDENCE OF DECEDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                            |             |                                                                                                                                                                                                     |                                                                   |                                                                                      |                                                                         |                                                                                                           |                                                                                                     |                                                                                                                                             |  |                                         |  |                                                                 |  |
| 10a. STATE<br><u>Maryland</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                            | 10b. COUNTY |                                                                                                                                                                                                     |                                                                   | 10c. CITY, TOWN OR LOCATION<br><u>Baltimore</u>                                      |                                                                         |                                                                                                           | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |                                                                                                                                             |  |                                         |  |                                                                 |  |
| 10e. STREET AND NUMBER<br><u>3720 Frankford Avenue</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |             |                                                                                                                                                                                                     |                                                                   | 10f. ZIP CODE<br><u>21206</u>                                                        |                                                                         | 10g. CITIZEN OF WHAT COUNTRY?<br><u>United States</u>                                                     |                                                                                                     |                                                                                                                                             |  |                                         |  |                                                                 |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                        |             | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |                                                                   |                                                                                      | 14. RACE — American Indian, Black, White, etc.<br>Specify: <u>White</u> |                                                                                                           |                                                                                                     |                                                                                                                                             |  |                                         |  |                                                                 |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>9</u> College (1-4 or 5+) <u>College</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                            |             | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><u>Truck Driver</u>                                                                   |                                                                   |                                                                                      | 16b. KIND OF BUSINESS/INDUSTRY<br><u>Grocery</u>                        |                                                                                                           |                                                                                                     |                                                                                                                                             |  |                                         |  |                                                                 |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><u>William Hornberger</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                            |             | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><u>Magdeline Frasch</u>                                                                                                                        |                                                                   |                                                                                      |                                                                         |                                                                                                           |                                                                                                     |                                                                                                                                             |  |                                         |  |                                                                 |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><u>Mrs. Grace Hornberger</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                            |             | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>3720 Frankford Avenue Baltimore, Md. 21206</u>                                                  |                                                                   |                                                                                      |                                                                         |                                                                                                           |                                                                                                     |                                                                                                                                             |  |                                         |  |                                                                 |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><u>Parkwood Cemetery</u> <u>11/23/94</u>                                                                                                                                                                                |             |                                                                                                                                                                                                     | 20c. LOCATION — City or Town, State<br><u>Baltimore, Maryland</u> |                                                                                      |                                                                         |                                                                                                           |                                                                                                     |                                                                                                                                             |  |                                         |  |                                                                 |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><u>Mark T. Zavoyna</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |             | 22. NAME AND ADDRESS OF FACILITY<br><u>Leonard J. Ruck, Inc.</u><br><u>5305 Harford Road Baltimore, 21214</u>                                                                                       |                                                                   |                                                                                      |                                                                         |                                                                                                           |                                                                                                     |                                                                                                                                             |  |                                         |  |                                                                 |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><u>Ischemic Heart Disease - End Stage</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><u>Chronic Renal Failure</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br><u>Atrial Fibrillation</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br><u>3 months</u><br><u>73 months</u><br><u>3 years</u> |  |                                                                                                                                                                                                                                                                                                            |             |                                                                                                                                                                                                     |                                                                   |                                                                                      |                                                                         | Approximate Interval Between Onset and Death<br><u>73 months</u><br><u>73 months</u><br><u>3 years</u>    |                                                                                                     |                                                                                                                                             |  |                                         |  |                                                                 |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |             |                                                                                                                                                                                                     |                                                                   |                                                                                      |                                                                         | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |                                                                                                     | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |                                         |  |                                                                 |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                            |             |                                                                                                                                                                                                     |                                                                   |                                                                                      |                                                                         |                                                                                                           |                                                                                                     |                                                                                                                                             |  |                                         |  |                                                                 |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |             |                                                                                                                                                                                                     |                                                                   |                                                                                      |                                                                         |                                                                                                           |                                                                                                     |                                                                                                                                             |  |                                         |  |                                                                 |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                     |             | 28b. TIME OF INJURY<br><u>M</u>                                                                                                                                                                     |                                                                   | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |                                                                         | 28d. DESCRIBE HOW INJURY OCCURRED                                                                         |                                                                                                     |                                                                                                                                             |  |                                         |  |                                                                 |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                            |             | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                        |                                                                   |                                                                                      |                                                                         |                                                                                                           |                                                                                                     |                                                                                                                                             |  |                                         |  |                                                                 |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                            |             |                                                                                                                                                                                                     |                                                                   |                                                                                      |                                                                         |                                                                                                           |                                                                                                     | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><u>Shel Mahon D.O.</u>                                                                             |  | 29c. LICENSE NUMBER<br><u>AT2438946</u> |  | 29d. DATE SIGNED (Month, Day, Year)<br><u>November 20, 1994</u> |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><u>Union Memorial Hospital, Baltimore, Md. 21218</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                            |             |                                                                                                                                                                                                     |                                                                   |                                                                                      |                                                                         |                                                                                                           |                                                                                                     |                                                                                                                                             |  |                                         |  |                                                                 |  |
| 31. DATE FILED (Month, Day, Year)<br><u>NOV 21 1994</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                            |             | 32. REGISTRAR'S SIGNATURE<br><u>John A. ...</u>                                                                                                                                                     |                                                                   |                                                                                      |                                                                         |                                                                                                           |                                                                                                     |                                                                                                                                             |  |                                         |  |                                                                 |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                   |  |                                                                                                     |                                                                                                           |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>DAWAN SHARIF HAKIM                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                     |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>NOV 16 94                                                                                                                                                   |  | 3. TIME OF DEATH<br>4:31 P.M.                                                                       |                                                                                                           |
| 4. SOCIAL SECURITY NUMBER<br>215-88-3631                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                                                                                                                                                                      |  | 8. AGE (In yrs. last birthday)<br>17 YRS.                                                                                                                                                         |  | 7. DATE OF BIRTH (Month, Day, Year)<br>12/11/76                                                     |                                                                                                           |
| 9a. FACILITY NAME (If not institution, give street and number)<br>3753 LYNDALE AVE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE CITY 21213                                                                                                                                                                                                                                                         |  | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland                                                                                                                                              |  |                                                                                                     |                                                                                                           |
| 9c. COUNTY OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                   |  |                                                                                                     |                                                                                                           |
| 10a. STATE<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 10b. COUNTY                                                                                                                                                                                                                                                                                                         |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore                                                                                                                                                          |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |                                                                                                           |
| 10e. STREET AND NUMBER<br>3753 Lyndale Avenue                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                     |  | 10f. ZIP CODE<br>21213                                                                                                                                                                            |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA                                                                |                                                                                                           |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                                                                                                                                                    |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: Black                                    |                                                                                                           |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>9th Grade                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Student                                                                                                                                                                                               |  | 16b. KIND OF BUSINESS/INDUSTRY<br>High School                                                                                                                                                     |  |                                                                                                     |                                                                                                           |
| 17. FATHER'S NAME (First, Middle, Last)<br>Jamal Abdul Hakim                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                     |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Linda Catherine Daniels                                                                                                                      |  |                                                                                                     |                                                                                                           |
| 19a. INFORMANT'S NAME (Type/Print)<br>Linda C. Hakim                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                     |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3829 Ravenwood Avenue Baltimore, MD 21213                                                        |  |                                                                                                     |                                                                                                           |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                         |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>King Memorial Park                                                                                                                                                                                                               |  | DATE<br>11/22/94                                                                                                                                                                                  |  | 20c. LOCATION — City or Town, State<br>Baltimore, MD                                                |                                                                                                           |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Donald E. Gilover                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                     |  | 22. NAME AND ADDRESS OF FACILITY<br>Douglas Funeral Home<br>1701 McCulloh St., Balto. MD 21217                                                                                                    |  |                                                                                                     |                                                                                                           |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. Contort burst wound of head<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                   |  |                                                                                                     | Approximate Interval Between Onset and Death                                                              |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                   |  |                                                                                                     | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                   |  |                                                                                                     |                                                                                                           |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                   |  |                                                                                                     |                                                                                                           |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>XX YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) AT SCENE |  |                                                                                                                                                                                                   |  |                                                                                                     |                                                                                                           |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input checked="" type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                               |  | 28a. DATE OF INJURY (Month, Day, Year)<br>11/16/94                                                                                                                                                                                                                                                                  |  | 28b. TIME OF INJURY<br>UNK M                                                                                                                                                                      |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO     |                                                                                                           |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>KING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 28d. DESCRIBE HOW INJURY OCCURRED<br>subject shot self                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                   |  |                                                                                                     |                                                                                                           |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br>3753 LYNDALE AVE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                   |  |                                                                                                     |                                                                                                           |
| 29a. CERTIFIER (Check only)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>XX <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                   |  |                                                                                                     |                                                                                                           |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Sharon Locke MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                     |  | 29c. LICENSE NUMBER<br>O.C.M.E.                                                                                                                                                                   |  | 29d. DATE SIGNED (Month, Day, Year)<br>NOV 17, 1994                                                 |                                                                                                           |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Sharon Locke MD 111 Penn Street, Baltimore, Maryland 21201                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                   |  |                                                                                                     |                                                                                                           |
| 31. DATE FILED (Month, Day, Year)<br>NOV 21 1994                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                     |  | 32. REGISTRAR'S SIGNATURE<br>John Davidson                                                                                                                                                        |  |                                                                                                     |                                                                                                           |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                           |  |                                                                                                       |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Rodger Douglas Harris</i>                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  | 2. DATE OF DEATH<br>MONTH <i>11</i> DAY <i>15</i> YEAR <i>94</i>                                                                                                                                          |  | 3. TIME OF DEATH<br><i>8</i> <i>P</i> <i>M</i>                                                        |  |
| 4. SOCIAL SECURITY NUMBER<br><i>216-52-4766</i>                                                                                                                                                                                                                                                                                                                                                                                                      |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                     |  | 8. AGE (In yrs. last birthday)<br><i>44</i> YRS.                                                                                                                                                          |  | 7. DATE OF BIRTH (Month, Day, Year)<br><i>6-9-50</i>                                                  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>Johns Hopkins Bayview Med Ctr.</i>                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>BALTIMORE CITY</i>                                                                                                                                              |  | 9c. COUNTY OF DEATH<br><i>BALTIMORE CITY</i>                                                          |  |
| 10a. STATE<br><i>MARYLAND</i>                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 10b. COUNTY<br><i>n/a</i>                                                                                                                                                                                                                                                                      |  | 10c. CITY, TOWN OR LOCATION<br><i>BALTIMORE</i>                                                                                                                                                           |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO       |  |
| 10e. STREET AND NUMBER<br><i>824 ARGONNE DRIVE</i>                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  | 10f. ZIP CODE<br><i>21218</i>                                                                                                                                                                             |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>UNITED STATES</i>                                                 |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                       |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES <i>XX</i>                                                                                                                                         |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: <i>XX</i> |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>BLACK</i>                               |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (9-12) <i>8 TH</i>                                                                                                                                                                                                                                                                                                                                           |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><i>LABORER</i>                                                                                                                                                                   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>n/a</i>                                                                                                                                                              |  |                                                                                                       |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>ROBERT H. HARRIS</i>                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>EULA M. DOUGLAS</i>                                                                                                                               |  |                                                                                                       |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>EULA HARRIS</i>                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>501 E. PRESTON STREET, BALTIMORE, MD 21202</i>                                                        |  |                                                                                                       |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>VOSHELL MEMORIAL GARDENS</i>                                                                                                                                                                             |  | DATE<br><i>11-21</i>                                                                                                                                                                                      |  | 20c. LOCATION — City or Town, State<br><i>DUNDALK, MD</i>                                             |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                |  | 22. NAME AND ADDRESS OF FACILITY<br><i>WM. C. MARCH FH.-1101 E. NORTH AVENUE</i>                                                                                                                          |  |                                                                                                       |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                           |  | Approximate Interval Between Onset and Death<br><i>3 mos</i><br><i>&gt; 2 yrs</i>                     |  |
| a. <i>Progressive Multicystic leukoencephalopathy</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <i>Acquired Immune Deficiency Syndrome</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. _____<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. _____                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                           |  |                                                                                                       |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                           |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                           |  |                                                                                                       |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                           |  |                                                                                                       |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                                                                    |  | 28. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                           |  |                                                                                                       |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined                                                                                                                                                            |  | 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                         |  | 28b. TIME OF INJURY<br><i>M</i>                                                                                                                                                                           |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO           |  |
| 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                              |  |                                                                                                       |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                     |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                           |  |                                                                                                       |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                |  | 29c. LICENSE NUMBER<br><i>39864</i>                                                                                                                                                                       |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>11/16/94</i>                                                |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                           |  |                                                                                                       |  |
| 31. DATE FILED (Month, Day, Year)<br><i>NOV 19 1994</i>                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                                                                                                                                           |  |                                                                                                       |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

